Triangle Physical Therapy

519 Keisler Drive, Suite 204, Cary, NC 27518

Health History

Name_____ D.O.B._____

Past Medical History: Have you EVER been diagnosed with any of the following conditions?

□ Cancer	□ Depression	□ Osteoporosis	□ Thyroid problems
□ Chest Pain	□ Diabetes	□ High Blood Pressure	□ Lung problems
□ Rheumatoid Arthritis	□ Epilepsy	□ Pneumonia	□ Heart problems
□ Blood Clots	□ Seizures	□ Tuberculosis	□ Liver problems
□ Stroke	□ Mental Illness	□ Migraine Headaches	□ Kidney problems
□ Parkinson's	□ Multiple Sclerosis	□ Traumatic Injury	□ Scoliosis
□ Fibromyalgia	□ Skin Disorders	□ Menstrual Irregularities	□ Asthma
□ Gout	□ Psoriasis	□ Bone or Joint Problems	□ Chemical/Alcohol Dependency
□ Anemia	□ Neuropathy	□ Osteoarthritis	□ History of Infectious Disease
□ Ulcers	□ Hepatitis	□ Pelvic Inflammatory Disease	□ Urinary Tract Infection
□ Bleeding Disorders	□ HIV / AIDs	□ Sexually Transmitted Disease	□ Others_____

Are you Pregnant: Yes / No Are you trying to be pregnant? Yes / No Is there a possibility of pregnancy**:** Yes / No

Past Surgical History: Joint Replacement_____ Fractures _____

Tendon Repair _____ Pacemaker/Defibrillator_____ Stimulator_____ Others_____

Current Medications (Include all pain medications): _____

How often do you take?_____ AM / PM_____ Does the medication help with pain relief? **Y / N** _____

Allergies:_____ **Precautions/Restrictions:** _____

Health Habits: □ Caffeine □ Smoking ____/ PPD □ Alcohol □ Drugs □ Exercise - what kind _____ □ Others _____

Last Appointment with Referring Physician:_____ Next Appointment: _____

Previous Physical Therapy: Yes / No Date: _____ Reason _____ Results _____

Current or in past month home health services: Yes / No Reason:_____ Start Date: _____End Date:_____

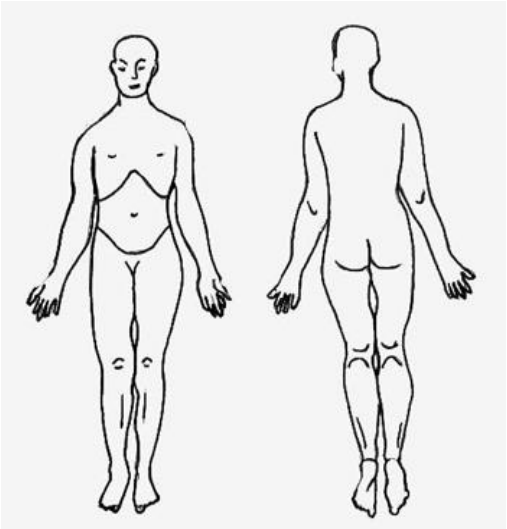
Special Tests: X- Rays Date: _____ Body Part:_____ MRI Date: _____ Body Part_____

Pain Behavior: Patient Complaint: _____Symptoms Start Date:_____

Reason for symptoms: □ Fall □ Auto Accident Date _____□ Sports_____ □ Exercise _____

□ Repetitive Activity _____ □Work Related explain:_____ □ Unknown □ Other_____

Painful Activity: □ Sitting □ Standing □ Sleeping □ Turning □ Lifting □ Walking □ Running □ Bending □ Sports □ Dressing □ Driving □ Cooking □ Reaching for Objects □ Bed/Chair/Car/Bathtub /Commode transfers □ Exercise □ Up/down Ramp/Curb/Steps □ Swimming □ Household activities □ Recreational activities □ Work □ Others _____



Location of Pain: Indicate "X" on the diagram

Rate your pain number below at its Best **AND** at its Worst:

Pain Rating Scale: 0 1 2 3 4 5 6 7 8 9 10

0 no pain	2 mild	5 moderate	8 severe	10 intolerable

Describe Type of Pain: _____

□ Cramping □ Aching □ Nagging □ Deep □ Sharp Shooting □ Toothache like

□ Burning □ Tingling □ Numbness □ Other _____

Any : □ Stiffness □ Soreness □ Weakness □ Balance disorder □ Dizziness □ Fatigue

Do you have lack of sensation anywhere? Yes / No Where? _____

What aggravates your pain? _____

What eases your pain? _____

Pain management tried: □ Heat □ Cold □ Medication □ Massage □ Exercise

□ Injections _____ □ Surgery _____ □ Other_____

Any health care provider seen for this problem? Yes / No Date: _____ Treatment _____ Results:_____

What are your goals from Physical Therapy: _____