COLORADO CENTER FOR PHYSICAL THERAPY

Neuromuscular Therapy • Pelvic Floor Pain & Rehabilitation • Orthopedic Rehabilitation

Confidential Health History Form

Date: ___/___/_____

Patient Name _____ **Height** _____ **Weight** _____

Date of Birth _____

Please list complaints/areas of concern in order of importance to you:

Complaint:	What brought it on?	What aggravates it?	What relieves it?
1. _____	_____	_____	_____
	_____	_____	_____
2. _____	_____	_____	_____
	_____	_____	_____
3. _____	_____	_____	_____
	_____	_____	_____

When did your symptoms start? _____

Have you been hospitalized for your primary complaint? No _____ **Yes** _____

Is your primary complaint interfering with activities at home? No _____ **Yes** _____ **Constant/intermittent**

Is your primary complaint interfering with your work? No _____ **Yes** _____ **Constant/intermittent**

Is your primary complaint preventing you from working? No _____ **Yes** _____

Has there been a medical diagnosis? No _____ **Yes** _____

X-ray _____ **MRI** _____ **Scan** _____ **Blood work** _____

Have you had this problem before? No _____ **Yes** _____ **If yes, when?** _____

What caused the episode? _____

What was the previous diagnosis? _____

What treatments helped? _____

Past Medical History:

List all past surgeries and dates: _____

_____

Any infections/illnesses/cancer: _____

List all broken bones: _____

Motor vehicle accidents/whiplash: _____

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