

Comprehensive Physical Therapy Center, Inc.
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2727 Madison Rd, Ste 301, Cincinnati, Oh 45209 (513) 871-5571
5382 Cox-Smith Rd Ste A, Mason, Oh 45040 (513) 336-7725

PATIENT HEALTH HISTORY FORM

NAME: _____

Have you ever had an allergic reaction to: Lotion Perfume Gel Latex Adhesives?

Have you ever been diagnosed as having any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer (if so, what type? _____) | <input type="checkbox"/> No <input type="checkbox"/> Yes Depression |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes High blood pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes Tuberculosis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Circulation problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes Kidney Disease |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Emphysema/Bronchitis | <input type="checkbox"/> No <input type="checkbox"/> Yes Anemia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Chemical dependency (i.e. alcoholism) | <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Thyroid problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Incontinence |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes Osteopenia/Osteoporosis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Multiple Sclerosis | <input type="checkbox"/> No <input type="checkbox"/> Yes Other _____ |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Rheumatoid arthritis | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Other arthritic conditions | |

At the present time, would you say your health is Excellent Very Good Fair Poor

During the past month have you been feeling down, depressed or hopeless? No Yes

During the past month have you been bothered by having little interest or pleasure in doing things? No Yes

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? No Yes

Has anyone in your immediate family (parents, brothers, sisters) been treated for any of the following?

- | | |
|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes Headaches |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes Kidney disease |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Mental illness |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes Alcoholism (chemical dependency) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes High blood pressure | |

Which of the follow over-the-counter medications have you taken in the last week?

- | | |
|---|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Aspirin | <input type="checkbox"/> No <input type="checkbox"/> Yes Antihistamines |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Tylenol | <input type="checkbox"/> No <input type="checkbox"/> Yes Antacid |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Advil/Motrin/Ibuprofen | <input type="checkbox"/> No <input type="checkbox"/> Yes Vitamins/mineral supplements |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Laxatives | <input type="checkbox"/> No <input type="checkbox"/> Yes Other _____ |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Decongestants | |

How much caffeinated or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

- | | |
|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Weight loss/gain | <input type="checkbox"/> No <input type="checkbox"/> Yes Weakness |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Nausea/vomiting | <input type="checkbox"/> No <input type="checkbox"/> Yes Fever/chills/sweats |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Dizziness/lightheadedness | <input type="checkbox"/> No <input type="checkbox"/> Yes Numbness or tingling |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Fatigue | <input type="checkbox"/> No <input type="checkbox"/> Yes Bowel or Bladder leakage |

Patient signature

date