

Comprehensive Physical Therapy Center, Inc.

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

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

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

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

Therapist signature

date

Patient signature

date