

Mullis & Associates
PHYSICAL THERAPY

EXPERIENCED. CONVENIENT.

HEALTH HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Why are you seeking Physical Therapy (i.e. back pain, knee pain, etc.)? _____

Date of injury or date that the pain recently increased: _____

How did this injury occur or what caused your pain to begin? _____

Have you had physical therapy in the past 12 months? _____ **Where?** _____

Emergency Contact Name: _____ **Phone:** _____

Please tell us how your pain is today. Place an X on the line below to rate your pain:

0-----10
No Pain *Unbearable Pain*

Medical History: Please check, if you have or have ever had any of the following?

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> History of fractures/broken bones |
| <input type="checkbox"/> Heart related issues | <input type="checkbox"/> MRSA/Staph infection |
| <input type="checkbox"/> Lung disease/breathing issues | <input type="checkbox"/> Vision or hearing problems |
| <input type="checkbox"/> Neurological problems (ex: seizure/stroke/MS) | <input type="checkbox"/> Osteoporosis/low bone density |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> History of cancer (type: _____) | <input type="checkbox"/> Unusual dizziness |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Increased pain at night |
| <input type="checkbox"/> Unexplained recent weight loss | <input type="checkbox"/> Changes in bowel/bladder function |
| <input type="checkbox"/> Recent increase in headaches | <input type="checkbox"/> Recent falls |
| <input type="checkbox"/> Changes in sensation (numbness/tingling) | <input type="checkbox"/> Drug or alcohol abuse issues |
| <input type="checkbox"/> Circulation or vascular problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | |

(Female Patients) Are you currently pregnant? **Yes** _____ **No** _____

Please List ALL Current Medications: _____

Please List ALL Surgeries and Approximate Dates: _____

Patient's Signature: _____ **Date:** _____

Therapist's Signature: _____ **Date:** _____