

HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING

Orthopedic Therapy and Sports Conditioning Facility

Name: _____ DOB: _____ Date: _____

Your Health History

Please check all health conditions that you currently have or have had in the past.

- AIDS/HIV
- Alcoholism
- Allergies
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorder
- Breast Lump
- Bronchitis
- Bulimia
- Kidney disease
- Cancer
- Cataracts
- Chemical dependency
- Chicken pox
- Depression
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Glaucoma
- Goiter
- Gout
- Heart disease
- Hepatitis
- Hernia
- Herniated disc
- High cholesterol
- High blood pressure
- Thyroid problems
- Liver disease
- Measles
- Migraine headaches
- Miscarriage
- Multiple Sclerosis
- Mumps
- Osteoporosis
- Pacemaker
- Parkinson's disease
- Pneumonia
- Polio
- Pregnant currently
- Prostate problems
- Prosthesis

- Psychiatric problems
- Rheumatoid arthritis
- Seizures
- Stroke
- Suicide attempt
- Tuberculosis
- Tumors
- Ulcers
- Other: _____

Please list any surgeries and date of surgery:

Please check any tests you have had for your present condition and describe results of test:

- XRAY
- MRI
- Bone scan
- CAT SCAN
- EMG
- Other _____

Please list all medications you are taking:

Please list any allergies:

Please describe location of your symptoms:

When describing your symptoms please circle all that apply:

- Constant / Intermittent /
- Sharp / Dull / Throbbing /
- Numbness / Aching / Burning /
- Pulling / Tingling / Cramps /
- Stiffness / Shooting / Swelling

Rate severity of pain: (0 no pain → 10 severe pain)

1 2 3 4 5 6 7 8 9 10

By signing below, I attest that all information given is true and accurate to the best of my ability.

SIGNATURE: _____

DATE: _____