ELEVATE PHYSICAL THERAPY

"Getting you back into life!"

ELEVATE Physical Therapy Health History Form

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

Please circle if you have you ever been diagnosed as having any of the following conditions:

Cancer, Thyroid Problems, Diabetes, Chronic urinary tract/bladder infection, Multiple Sclerosis, Pneumonia, Rheumatoid Arthritis, Bone or joint infection, Degenerative Osteoarthritis, Other infections, Gout, Pelvic inflammatory Disease, Ankylosing Spondylitis, Heart Attack, Hepatitis, Heart Problems, Stomach/duodenal Ulcers, High Blood Pressure, Epilepsy/Seizures, Stroke (including mini-stroke/TIA), Headaches, Deep Vein Thrombosis (DVT), Endometriosis, Anemia/low blood levels, Urinary Incontinence, Emphysema, Osteoporosis, Asthma, Neurological Disease, Chemical Dependency (ex. Alcoholism), Tuberculosis, Depression

Other Conditions _____

Surgeries:

Type: _____ Date_____
Type: _____ Date_____
Type: _____ Date_____
Type: _____ Date: _____
Type: _____ Date: _____

Over the Counter medications:

Advil, Motrin, Ibuprofen, Aleve
Aspirin, Tylenol/Acetaminophen
Decongestants/Antihistamines
Other: _____
_____

Current Condition / Chief Complaint: **Date of Onset**: _____

Describe the problems for which you seek physical therapy:

_____

_____

Pain Level: Please rate your pain on a scale of 0/10. 0 being no pain, 10 being severe pain.

Current pain: _____ Best pain: _____ Worst pain: _____

What are your goals in physical therapy? _____

_____

_____