Outpatient Therapy
Health History Form

parkview MEDICAL CENTER

1. **Please list the primary reason you are here:** _____

2. **Please list your medications (including over the counter medications, laxatives and herbals):**

_____

_____

3. **Please list any known food or drug allergies:**

_____

4. **Are you allergic to Latex? Yes _____ No_____**

5. **Does one doctor and one pharmacist manage all of your medications? Yes___ No _____**

6. **Please checkmark (☒) any of the following tests you have had recently:**
   - **a. MRI_____** **b. CT scan _____**
   - **c. Bone Scan _____** **d. X-ray _____**
   - **e. EKG _____** **f. Other _____**

7. **Is there a chance you could be pregnant? Yes _____ No _____**

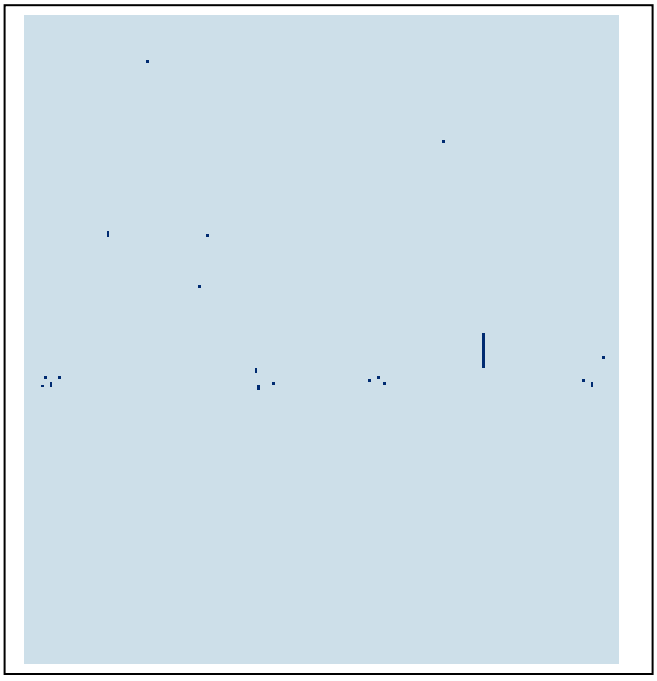
8. **Do you get dizzy? Yes _____ No_____**
   If yes, when? _____

9. **Have you fallen in the last few months? Yes _____ No _____**

10. **Is this a work related injury? Yes_____ No _____**

11. **Are you receiving home health? Yes _____ No _____**

12. **If you have pain, please shade in any areas of discomfort you are currently experiencing:**



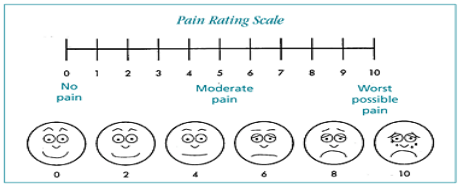
13. **Does your pain wake you up at night?**
    Yes _____ No_____

14. **Which of the following make your symptoms worse? (Please ☒)**
    - **Morning _____**
    - **Daytime _____**
    - **Evening _____**
    - **Sitting _____**
    - **Standing _____**
    - **Walking _____**
    - **Lying Down _____**
    - **Bending _____**
    - **Rising from sitting _____**

15. **What other things make your pain worse?** _____

16. **What makes your pain better?** _____

17. On a scale of 1-10 what would you rate your pain in these areas?



Now_____ Best in the last week _____ Worst in last week_____

18. Please list any surgeries you have had in the past:

_____

19. Have you or your immediate family (parent, sibling) ever been diagnosed with any of the following health conditions? (Please check ✓)

	Me		Family	
	YES	NO	YES	NO
High blood pressure				
Heart disease/ Heart attack				
Pacemaker/Defibrillator				
Thyroid Problems				
Hepatitis				
Stroke or TIA's				
Diabetes				
Seizures or epilepsy				
Hearing loss				
Kidney/Liver problems				
Cancer				
Osteoporosis				
Rheumatoid Arthritis				
Other arthritic problems				
Digestive Problems				
Bowel/Bladder Problems				
Anemia				
Asthma/Emphysema/COPD				
Lupus				
Bleeding Tendencies				
Tuberculosis				
Headaches				

20. Please list any other medical conditions not listed above.

_____

21. Do you smoke? Yes _____ No _____ If yes, how much? _____

22. Do you drink alcoholic beverages? Yes ____ No _____ If yes, how often?_____

23. How many caffeinated drinks (cups of coffee or 12 oz sodas) do you consume a day? _____

24. Have you experienced any recent unexplained weight loss or weight gain? Yes ____ No _____

25. Have you been ill recently? (i.e fever, respiratory illness, nausea, chills, etc) Yes ____ No _____

26. Do you suffer from unexplained fatigue? Yes _____ No_____

27. Do you have any numbness or tingling? Yes _____ No _____ If yes, where? _____

28. Is there anything else we should know before we treat you?_____

Patient Signature: _____ Date _____