Therapeutic Evolution PT

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Albany, NY 12203
P: 518-512-3452
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Health Status Form

Date: | Patient Name:

Present Complaint: | Date of Onset:

How did injury occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other _____

Do you have pain? ☐ Yes ☐ No | Rate Pain (0 no Pain – 10 high pain) At Best: _____ At Worst: _____

Have you had physical therapy for this problem before? ☐ Yes ☐ No | If yes, when:

What tests have been done for this condition? (check all that apply)

☐ CT Scan ☐ MRI ☐ X Ray ☐ EMG ☐ Bone Scan ☐ Ultrasound ☐ None ☐ Other _____

Describe your overall general health : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History

If yes, please provide details

High Cholesterol	☐ Yes	☐ No	_____	Stroke	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____	Blood Clots	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____	Pacemaker	☐ Yes	☐ No	_____
Seizures/Neurological	☐ Yes	☐ No	_____	Cancer/Tumor	☐ Yes	☐ No	_____
Behavioral/Learning	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Anxiety/Depression	☐ Yes	☐ No	_____	Hepatitis/HIV	☐ Yes	☐ No	_____
Genetic/Congenital	☐ Yes	☐ No	_____	Asthma/COPD	☐ Yes	☐ No	_____
Are you pregnant?	☐ Yes	☐ No	_____	Do You Smoke?	☐ Yes	☐ No	_____
Bone Joint Problems	☐ Yes	☐ No	_____	If so, how much?			_____

Other (describe): _____

Significant Past Surgeries: _____

Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: _____

_____

_____

List all food and medical allergies (include latex & adhesives): _____

_____

_____

Daily Activities

What do your job and/or home duties require? Check all that apply:

☐ Computer Work	☐ Standing	☐ Reaching	☐ Carrying
☐ Kneeling/Squatting	☐ Walking	☐ Climbing	☐ Lifting
☐ Repetitive Movement/Twisting	☐ Writing	☐ Pushing/Pulling	☐ Other _____

_____ _____

Signature of Patient or Legally Authorized Representative | Date