FYZICAL Campbell

Patient Health History

Name _____ Date _____

Body part(s) we will be treating: _____

When and how did your current symptoms start? _____

Since they started, are you symptoms: better / worse / same _____

Have you had any diagnostic tests for this problem? Please list results.

- ☐ X-Ray _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ EMG _____
- ☐ Other _____

What treatment have you received for this problem? _____

Was it helpful? Yes No

☐ Patient is Pediatric **(Skip down to special support section)**

What is your occupation? _____

What is your current work status? full duty / modified duty / off work since _____ or N/A

Do you smoke? No Yes # of packs a day _____

Do you use any special supports?

- ☐ Back cushion / neck cushion
- ☐ Splints
- ☐ Tape
- ☐ Back brace / corset
- ☐ Orthotics (including heel lifts and arch supports)
- ☐ Other _____

Please describe your current exercise routine: _____

_____

Are you currently taking any medications? **Please provide a list with medications and dosage if possible.**

- ☐ Aspirin
- ☐ Tylenol / Acetaminophen
- ☐ Advil / Motrin / Ibuprofen
- ☐ Other pain reliever _____
- ☐ Decongestants
- ☐ Antihistamines
- ☐ Laxatives
- ☐ Antacids
- ☐ Muscle relaxers
- ☐ Blood pressure medicine
- ☐ Stimulants
- ☐ Other _____

Please list any vitamins or supplements you are currently taking: _____

_____

_____

Please check each of the diseases or conditions that you have currently or have had in the past:

- ☐ Frequent headaches or migraines
- ☐ Fever / chills / night sweats
- ☐ Dizziness
- ☐ Numbness or tingling
- ☐ Increase in symptoms when you cough or sneeze
- ☐ Heart Problems
- ☐ High blood pressure
- ☐ Emphysema / bronchitis
- ☐ Diabetes Type 1 or Type 2
- ☐ Allergy
- ☐ Stroke
- ☐ Rheumatoid arthritis
- ☐ Scoliosis
- ☐ Osteoporosis / Osteopenia
- ☐ Cancer, If YES, what kind _____
- ☐ Fatigue
- ☐ Nausea / vomiting
- ☐ Weakness
- ☐ Urinary or bowel difficulty
- ☐ Disturbed sleep
- ☐ Circulation problems
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Blood clots
- ☐ Tuberculosis
- ☐ Epilepsy / seizures
- ☐ Other arthritic conditions (Gout, Psoriatic)
- ☐ Hernia
- ☐ Head trauma / concussion
- ☐ Other _____

Have you had 2 or more falls, or a fall with injury in the past year? Yes No

Women, is there any possibility that you are pregnant? Yes No

Please list any surgeries (inpatient or outpatient) or conditions for which you have been hospitalized.

_____

_____

_____

Is there anything else you would like us to know about you?

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