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

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: ____

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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:____

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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.

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Please list any scars and their locations: ________________________________

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

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