HEALTH HISTORY FORM

Patient Name	Date								
Allergies: List any medication(s) you are allerg	jic to:								
Current medications / vitamins / supplements:									
Do you smoke? Yes / No how much:Do you drink alcohol? Yes / No how much									
Do you consume caffeinated beverages? Yes	/ no how much:								
Are you engaged in any regular exercise? Plea	ase describe:								
Are you under a lot of pressure or stress? Ye Do you have a pacemaker, transplanted organ	es / no please describe: n, joint replacement, or metal implants?								
Have you had any illness in the last 3 weeks (colds, flu, bladder or kidney infection)?								
Females Only : Are you pregnant or planning Severe troublesome menstrual cramps? Have you ever been diagnosed with?	g a pregnancy?								
O O	Pelvic inflammatory disease Endometriosis Other gynecological or obstetrical difficulties? e disease / cancer or infection:								
Have you ever had any of the following?	(check all that apply)								

Please explain any positive answer from previous page here: _

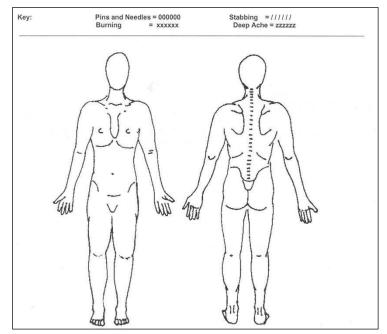
Family History

Alcoholism (chemical dependency)	Kidney disease	
Diabetes	Mental illness	
Cancer	Osteoporosis	
Heart attack	Rheumatoid arthritis	
High blood pressure	Stroke	
Heart disease	Thyroid disease / dysfunction	

Have you recently noted?

- Fatigue Fever / chills / sweats
- Nausea / vomiting
- Numbness / tingling
- Weakness
- Weight gain / loss

HEALTH HISTORY FORM



Please rate your current level of pain on the following scale (mark line):

0	1	2	3	4	5	6	7	8	9	10
(no	o pai	in)		(woi	st i	mag	gina	ble	pain)

Please rate your worst level of pain in the last 24 hours on the following scale (mark line):

0	1	2	3	4	5	6	7	8	9	10
(n	o pa	ain)		(wor	st in	nagi	nabl	e pa	uin)

Please list 3 activities that you are having difficulty doing or are unable to do. Please rate these activities on following scale.

	0 Unat To p Activ	erform	2	3	4	5	6	7	8	9	the	e to do same as ore injury
Example: Climb Stairs 8												
Activity									Baseline		6-week	1-year
									<u>Score</u>		<u>Score</u>	<u>Score</u>
1.												
2.												
3.												
Patient Sig	nature	<u>X</u>							[Date	<u>X</u>	
Therapist S	Signatu	ıre <u>X</u>							C	Date	<u>x</u>	

Arvada

Phone: 303-456-2671