



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 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Seizures/Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Cancer/Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Behavioral/Learning	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hepatitis/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Genetic/Congenital	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Asthma/COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Do You Smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bone Joint Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			

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 does 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 _____