HEALTH HISTORY

FIRST NAME

LAST NAME

GENERAL HEALTH

Age: _____ Height: _____ Weight: _____

Dominant hand: ☐ Right ☐ Left

How would you rate your overall health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Are you pregnant?

☐ No ☐ Yes Due Date: _____

Apart from your daily activities, do you exercise?

☐ 5+ days per week
☐ 3–4 days per week
☐ 1–2 days per week
☐ Occasionally
☐ None

Do you smoke?

☐ No ☐ Yes Packs per day: _____

Circle your current stress level.

LOW 1 2 3 4 5 6 7 8 9 10 HIGH

MEDICATION

List any prescription and/or over-the-counter medications you are currently taking *(pain pills, injections, skin patches, aspirin, multivitamins, etc.)*

☐ See attached list

_____

_____

_____

DAILY LIVING

What's your current living situation?

☐ Live alone
☐ Live with family/others/caregiver
☐ Home / Apartment / Retirement Complex
☐ Assisted living
☐ Other: _____

Do you drive? ☐ Yes ☐ No

PAST & CURRENT MEDICAL HISTORY

Check/list if you've had any of the following diagnoses:

☐ Allergies
☐ Arthritis (OA)
☐ Arthritis (RA)
☐ Blood Disorder/Anemia
☐ Cancer
☐ Chemical Dependency
☐ Circulatory/Vascular Problems
☐ Depression
☐ Diabetes
☐ Epilepsy/Seizures/Dizziness
☐ Fractures
☐ Head Injuries
☐ Heart Problems
☐ High Blood Pressure
☐ HIV
☐ Infectious Disease
☐ Incontinence
☐ Kidney Problems
☐ Lung Problems/Asthma
☐ Parkinson's
☐ Spine Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Other: _____

FAMILY HISTORY

Check/list if a family member has had any of the following diagnoses:

☐ Arthritis (OA)
☐ Arthritis (RA)
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ Psychological Condition: _____
☐ Stroke

PREVIOUS FUNCTION LEVEL

How independent were you with self-care activities?

☐ Independent (bathing, toileting, dressing, etc.)
☐ Difficulty performing self-care activities
☐ Need assistance with self-care activities
☐ Difficulty performing household chores

Were you limited in social, recreational, or leisure activities?

☐ No limitations ☐ Limited in: _____

WORK HISTORY

☐ Full-time
☐ Part-time
☐ Student
☐ Self-employed
☐ Unemployed
☐ Retired

Occupation: _____

How would you describe your physial activites?

☐ Computer use
☐ Driving
☐ Heavy lifting
☐ Phone use
☐ Repetitive lifting
☐ Sitting
☐ Standing
☐ Other: _____

What's your current work level?

☐ Full duty ☐ Restricted duty ☐ Missed days

Do you plan to return to your previous work level? ☐ Yes ☐ No

Is this a Worker's Compensation claim? ☐ Yes ☐ No

Are you seeking disability or using an attorney for this condition?

☐ Yes ☐ No