CONSULTATION PHYSICAL THERAPY
of TEXAS
RETURNING YOU TO THE GAME OF LIFE

PATIENT HISTORY FORM

Date: ____/____/_____ ☐ Minor (under 18 years old)

NAME: _____ Birthdate: ____/____/_____
Last First MI

Age: _____ Sex: ☐ F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Date of Onset: ____/____/_____
Describe the cause of onset of symptoms:

Please list the names of the other practitioners and treatments you have received you for this problem:

Testing preformed: ☐ X-rays ☐ MRI ☐ CT ☐ Ultrasound ☐ EMG/NCV ☐ other _____

Have you been hospitalized for your current condition? ☐ No ☐ Yes, when and what hospital?

Have you had surgery for your current condition? ☐ No ☐ Yes, when and what surgical procedure?

Do you smoke? ☐ No ☐ Yes, _____ packs per day and for _____ years
Do you drink alcohol? ☐ No ☐ Yes, _____ drinks per day/week and for _____ years
Current or Past substance (legal or illegal) abuse? ☐ No ☐ Yes, last used and what substance? _____

CURRENT MEDICATIONS

Drug allergies: ☐ No ☐ Yes, To what? _____
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of Drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Practitioner's Initials: _____

PAST MEDIAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type)_____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke or TIA
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or Peptic Ulcer
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Allergies: _____

Other medical conditions (please list) _____

_____

SURGICAL HISTORY

List Surgeries and Dates: _____

_____

_____

PERSONAL HISTORY

Were there problems with your birth? ☐ No ☐ Yes, be specific _____

Where were you born & raised? _____

What is your highest education? ☐ Elementary ☐ Junior High School ☐ High School ☐ Some College ☐ College Graduate ☐ Advance Degree

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/Significant Other

What is your current or past occupation? _____

Are you currently working? ☐ No ☐ Yes If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ No ☐ Yes, for what disability & how long? _____

Religion:

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age (s)	Health Problems	Age (s)	Causes
Father				
Mother				
Siblings				
Children				

HOME & MEDICAL EQUIPMENT

Home setting: ☐ Single Story House ☐ Two Story House ☐ Condo ☐ Apartment ☐ Other_____

# of Stairs/Steps at Home: ____ ☐ Handicap Ramp ☐ Elevator

Bathroom: ☐ Walk in Shower ☐ Tub Shower ☐ Tub only

Medical Equipment: ☐ Cane ☐ Walker ☐ Hand Rails ☐ Lift ☐ Other _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ☐ Recent Weight Gain; ____lbs
- ☐ Recent Weight Loss; ____lbs
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night Sweats

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Joint Swelling

Where?

EARS
- ☐ Ringing in Ears
- ☐ Loss of Hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of Vision
- ☐ Double or Blurred Vision
- ☐ Dryness

THROAT
- ☐ Frequent Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Pain in Jaw

HEART & LUNGS
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Swollen Legs or Feet
- ☐ Cough

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or Loss of Consciousness
- ☐ Numbness or Tingling
- ☐ Memory Loss

STOMACH & INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Yellow Jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Black Stools

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/ Bumps
- ☐ Hair Loss
- ☐ Color Changes of Hands or Feet

BLOOD
- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine

Women Only:
- ☐ Abnormal Pap Smear
- ☐ Irregular Periods
- ☐ Bleeding Between Periods
- ☐ PMS

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Difficulty with Sexual Arousal
- ☐ Poor Appetite
- ☐ Food Cravings
- ☐ Frequent Crying
- ☐ Sensitivity
- ☐ Thoughts of Suicide/Attempt
- ☐ Stress
- ☐ Irritability
- ☐ Poor Concentration
- ☐ Racing Thoughts
- ☐ Hallucinations
- ☐ Rapid Speech
- ☐ Guilty Thoughts
- ☐ Paranoia
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Risky Behavior

OTHER PROBLEMS:

_____

_____

_____

_____

_____

WOMENS REPRODUCTIVE HISTORY:

Age of First Period: _____

Do you have regular periods? Y / N

Date of Last Period: ____/____/_____

Reached Menopause? Y / N

Age of Onset: _____

# of Pregnancies: _____

# of Miscarriages: _____

# of Abortions: _____

Vaginal _____ C-section _____

Patient Signature _____ Date: _____

Practitioner's Initials: _____