



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

**PATIENT HISTORY FORM**

Date: ___/___/___	<input type="checkbox"/> Minor (under 18 years old)
NAME: _____	Birthdate: ___/___/___
Age: _____	Sex: <input type="checkbox"/> F <input type="checkbox"/> 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 performed: <input type="checkbox"/> X-rays <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> Ultrasound <input type="checkbox"/> EMG/NCV <input type="checkbox"/> other _____	
Have you been hospitalized for your current condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, when and what hospital?	
Have you had surgery for your current condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, when and what surgical procedure?	
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ packs per day and for _____ years	
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ drinks per day/week and for _____ years	
Current or Past substance (legal or illegal) abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes, last used and what substance? _____	

CURRENT MEDICATIONS		
Drug allergies: <input type="checkbox"/> No <input type="checkbox"/> 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:

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

Practitioner's Initials: \_\_\_\_\_

## 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:

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### WOMENS REPRODUCTIVE HISTORY:

Age of First Period: \_\_\_\_\_

Do you have regular periods? Y / N

Reached Menopause? Y / N

# of Pregnancies: \_\_\_\_\_

Date of Last Period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age of Onset: \_\_\_\_\_

Vaginal \_\_\_\_\_ C-section \_\_\_\_\_

# of Miscarriages: \_\_\_\_\_

# of Abortions: \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

Practitioner's Initials: \_\_\_\_\_