Dee PT
integrated rehabilitation • therapy • fitness

Name:_____
DOB:_____Age:_____
Todays Date:_____
Clinic: SR HB SAC

Client History Information

****Please fill out to the best of your ability and focus on what is pertinent to your visit with us today****

General Health Status

Please rate your health: __ Excellent __ Good __ Fair __ Poor
Exercise: __ None __Moderate __Daily __Heavy __Athlete
Health Habits: __Alcohol __Water __Coffee/Caffeine __Stress __Tobacco
Any Major Life Changes in the Last Year? (eg, new baby, job change, death in the family) __ Yes __No
If yes, please describe: _____

Family History

Please list if your father, mother, sibling, aunt/uncle or grandparent has had any of the following conditions and the age of onset if known.

Arthritis: _____ Cancer: _____
Diabetes: _____` Heart Disease: _____
Hypertension: _____ Osteoporosis: _____
Psychological: _____ Stroke: _____
Other: _____ Other: _____

Medical/Surgical History Please check if you have ever had:

__Arthritis	__Heart Problems	__Muscular Dystrophy
__Asthma	__High Blood Pressure	__Osteoporosis
__Blood Disorders	__High Cholesterol	__Parkinsons
__Cancer	__Infectious Disease (TB, Hepatitis)	__Repeated Infections
__Circulation/Vascular Problems	__Kidney Problems	__Seizures/Epilepsy
__Covid-19	__Low Blood Sugar/Hypoglycemia	__Skin Disease
__Depression	__Lung Problems	__Stroke
__Developmental/Growth Issues	__Migraine Headaches	__Thyroid Problems
__Diabetes/High Blood Sugar	__Multiple Sclerosis	__Ulcers/Stomach Problems
__Head Injury	Other:_____	

Broken Bones/Fractures (include dates) Surgeries (include dates)
_____ __/__/__ _____ __/__/__
_____ __/__/__ _____ __/__/_

Allergies: _____
Supplements/Herbs: _____
_____
Medications: (Dosage and Frequency)_____
_____

Insurance requires the following information for ALL PATIENTS

Height* _____ Weight* _____
**Have you fallen in the past year? Yes / No
**If you have fallen in the past year, did you sustain an injury from that fall? Yes / No

Turn Over

Employment/Recreation

Hobbies/Sports: _____

Current Employment: Occupation _____ __Part-time __Full-time

Work Activity: __ None __ Sitting __Standing __Light Labor __Heavy Labor

Out of Work Due to Injury?: __No __Yes, please describe: _____

Work Restrictions?: __No __Yes, please describe: _____

Current Condition/Chief Complaint

Reason for Visit: _____

Is this condition: ___A New Problem __A Chronic Problem __Unknown

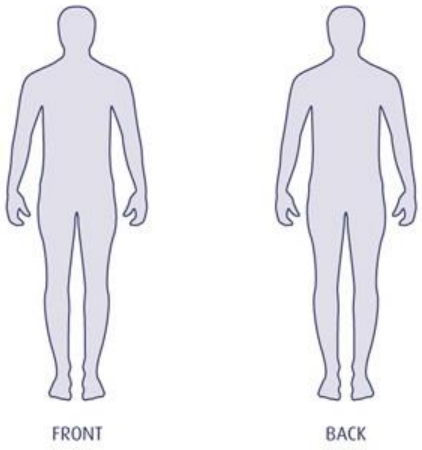
When did symptoms appear?: _____ Is it getting worse?: __Yes __No __Unknown

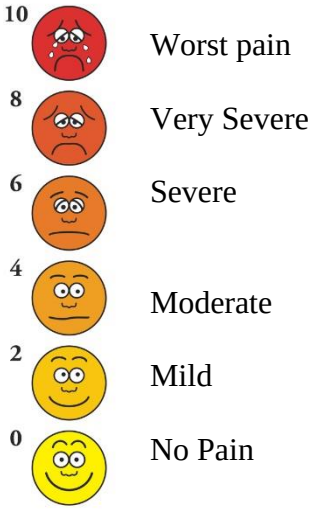
What makes the problem(s) better?: _____

What makes the problem(s) worse?: _____

What are your goals for physical therapy?: _____

Please circle the location of your pain or where you may be having difficulty functioning, and circle your level of pain on the right.





Are you seeing anyone else for the problem(s)?: *Please check all that apply*

__Acupuncturist	__Cardiologist	__Chiropractor	__Dentist
__Family Practitioner	__Internist	__Massage Therapist	__Neurologist
__OBGYN	__OT	__Orthopedist	__Osteopath
__Pediatrician	__Podiatrist	__Primary Care Dr.	__Rheumatologist

__Other: _____

PHQ-2 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Patient/Guardian Signature: _____ Date: _____

Turn Over