

Merz Physical Therapy
Health History Form

In order to help us fully evaluate you, please provide us with the following important background information. If you do not understand a question, ask or leave it blank and your therapist will assist you. Thank you!

Name _____ Date of Birth _____ Height _____ Weight _____

Reason for visit _____ Occupation _____

Allergies: List any medication(s) you are allergic to _____

List any other allergies we should know about _____

Have you declared the "Advanced Clinical Directive" or DO NOT RESUSCITATE? YES NO

Please check any of the following whose care you are under:

_____ Medical Doctor	_____ Psychiatrist/Psychologist	_____ Nutritionist
_____ Osteopath	_____ Physical Therapist	_____ Other _____
_____ Dentist	_____ Chiropractor	

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, routine check-up):

Have you **EVER** been diagnosed as having any of the following conditions?

YES	NO	Cancer	If YES, describe what kind: _____			
YES	NO	Heart Problems		YES	NO	Headaches
YES	NO	High Blood Pressure		YES	NO	Rheumatoid Arthritis
YES	NO	Circulation Problems		YES	NO	Other Arthritic Conditions
YES	NO	Asthma		YES	NO	Depression
YES	NO	Emphysema/Bronchitis		YES	NO	Hepatitis
YES	NO	Chemical Dependency (i.e. Alcoholism)		YES	NO	Tuberculosis
YES	NO	Thyroid Problems		YES	NO	Stroke
YES	NO	Diabetes		YES	NO	Kidney Disease
YES	NO	Multiple Sclerosis		YES	NO	Anemia
YES	NO	Epilepsy		YES	NO	Other

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

<u>DATE</u>	<u>REASON FOR SURGERY/HOSPITALIZATION</u>		
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains), and the approximate date of injury:

<u>DATE</u>	<u>INJURY</u>		
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Has anyone in your **immediate family** (parents, siblings) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer if so, what kind _____
YES	NO	Tuberculosis	YES	NO	Arthritis
YES	NO	Heart Disease	YES	NO	Anemia
YES	NO	High Blood Pressure	YES	NO	Headaches
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Kidney Disease	YES	NO	Mental Illness
YES	NO	Chemical Dependency (Alcoholism)			

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

YES	NO	Aspirin
YES	NO	Tylenol
YES	NO	Advil/Motrin/Ibuprofen
YES	NO	Laxatives
YES	NO	Decongestants
YES	NO	Antihistamines
YES	NO	Antacid
YES	NO	Vitamins/Mineral Supplements
YES	NO	Other _____

Please list any **PRESCRIPTION** medication you are currently taking **INCLUDING** pills, injections, and/or skin patches:

1. _____	2. _____	3. _____
4. _____	5. _____	4. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass or wine, how much do you drink at an average sitting? _____

Are you currently trying to lose weight or would you like to lose weight? _____

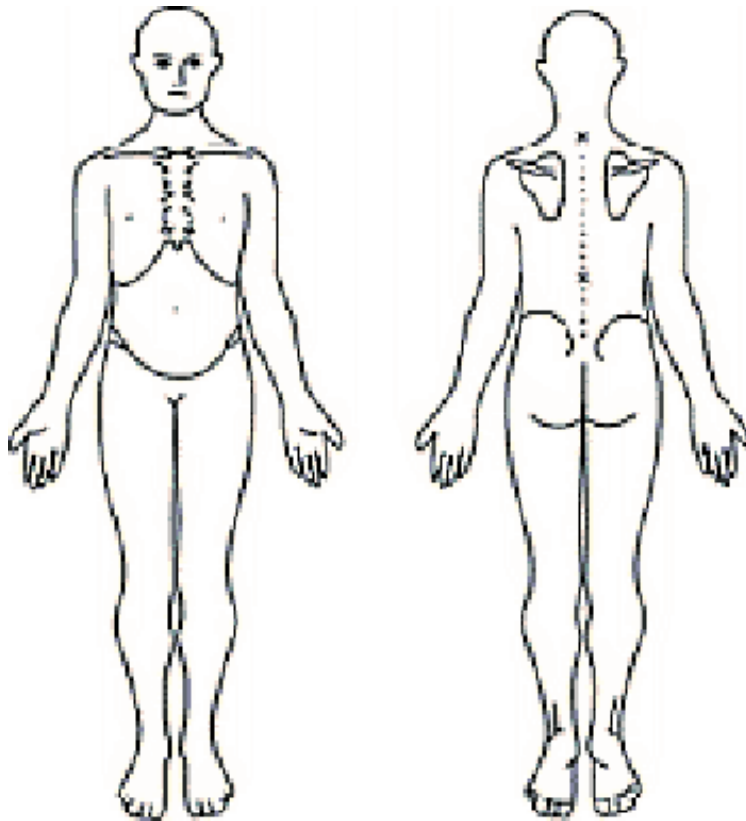
Have you recently noted:

- | | | |
|-----|----|----------------------|
| YES | NO | Weight loss/Gain |
| YES | NO | Nausea/Vomiting |
| YES | NO | Fatigue |
| YES | NO | Weakness |
| YES | NO | Fever/Chills/Sweats |
| YES | NO | Numbness or tingling |

Therapist Signature

Date

Draw Your Pain



X = Pain

O = Numbness

Shading = Area of Discomfort