

**PRIMARY THERAPY SOURCE** ◆◆◆ **ADULT HEALTH HISTORY** ◆◆◆ **DATE** \_\_\_\_\_

**PATIENT** LastName \_\_\_\_\_ FirstName \_\_\_\_\_ Middle Init \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Left Handed  Right Handed Do you smoke?  No  Yes  Cigarettes  Cigars  Pipe

Alcohol Consumption:  No  Yes Amount: Glasses/Day \_\_\_\_\_ /Week \_\_\_\_\_ /Month \_\_\_\_\_

**Who referred you?** \_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_

**What problem are you here for today?** \_\_\_\_\_

**Date of injury or length of time you've had problem** \_\_\_\_\_

**Recent Surgery?**  No  Yes Describe \_\_\_\_\_ Date \_\_\_\_\_

**Relevant past surgery?** Describe \_\_\_\_\_ Date \_\_\_\_\_

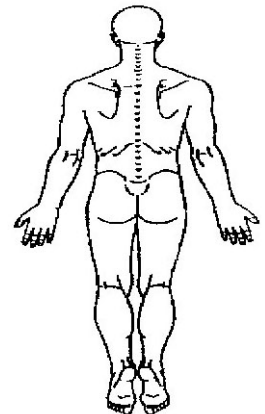
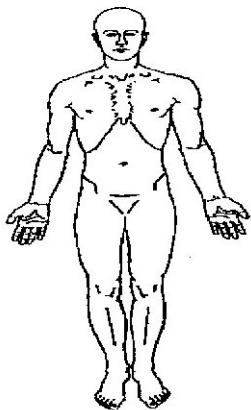
**Check the boxes that describe your pain during the day:**

	Out of Bed	Morning	At Work	Afternoon	At Work	Evening	In Bed
Worse							
Better							

**Circle the number that represents your pain today.** 0 = no pain, 10 = extreme pain

0 1 2 3 4 5 6 7 8 9 10

**On the drawings below, please indicate where you have symptoms**



**Does your pain wake you up at night?**  No  Yes If yes, how frequently? \_\_\_\_\_

**Is your pain changing over time?**  No  Yes  Getting worse  Getting better

**What activities or positions increase your symptoms** \_\_\_\_\_

**What activities or positions reduce your symptoms** \_\_\_\_\_

**Have you had this problem before?**  No  Yes When \_\_\_\_\_

**Have you received treatment for this condition in the past?**  No  Yes **Describe treatment:** \_\_\_\_\_

**Are you being treated for this condition by other healthcare providers?**  No  Yes **Describe:** \_\_\_\_\_

**Are you currently taking medication for this or any other condition?**  No  Yes

If yes, list names & amounts of both prescription & non-prescription medication: \_\_\_\_\_

**Have you had any of the following tests for your current condition?**

X-Ray  MRI  CT Scan  Bone Scan  Electrical Nerve Tests  
 Other \_\_\_\_\_ Results \_\_\_\_\_

**Are you working?**  Full Duty  Light Duty  No Last day worked \_\_\_\_\_  
 Homemaker  Retired  Student Occupation \_\_\_\_\_

**Rate the physical demand of your work and recreation activities:**  
 Heavy  Moderate  Light  Sedentary Specifics \_\_\_\_\_

**Indicate if you have experienced any of the following with your current problem:**

<input type="checkbox"/> loss of balance	<input type="checkbox"/> pain with coughing/sneezing	<input type="checkbox"/> numb/tingling in the extremities
<input type="checkbox"/> dizziness	<input type="checkbox"/> nausea	<input type="checkbox"/> numb/tingling in the face
<input type="checkbox"/> forgetfulness	<input type="checkbox"/> difficulty with concentration	<input type="checkbox"/> loss of bowel/bladder control
<input type="checkbox"/> dropping items	<input type="checkbox"/> changes in vision/taste/voice	<input type="checkbox"/> popping in your jaw
<input type="checkbox"/> night pain	<input type="checkbox"/> numb/tingling around groin/buttock	

**Do you currently have (or previously had) problems with any of the following:**

<input type="checkbox"/> lungs	<input type="checkbox"/> stomach/bowel	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> blood
<input type="checkbox"/> heart	<input type="checkbox"/> kidney/bladder/genital	<input type="checkbox"/> nervous system	<input type="checkbox"/> viral infections
<input type="checkbox"/> diabetes	<input type="checkbox"/> reproductive system	<input type="checkbox"/> muscles or bones	<input type="checkbox"/> recent infections
<input type="checkbox"/> arthritis	<input type="checkbox"/> recent weight loss/gain	<input type="checkbox"/> unusual/frequent headaches	<input type="checkbox"/> HIV
<input type="checkbox"/> depression/psychological	<input type="checkbox"/> cancer: location _____		
<input type="checkbox"/> vision impairment	Describe _____		
<input type="checkbox"/> hearing impairment	Describe _____		

**Are there any other family members with similar problems?**  No  Yes If yes, describe: \_\_\_\_\_

**Men:** Diagnosed with or suspect you have prostate disease  Impotence

**Women:** Have you been diagnosed with  Pelvic Inflammatory Disease  Endometrioses  
Are you or do you think you are pregnant  No  Yes  
 Other gynecological problems \_\_\_\_\_

**With whom do you live?**  
 Alone  Spouse Only  Spouse & Children  Child(ren)  Others  
 Personal care attendant  Group Setting Where do you live? \_\_\_\_\_

<b>Does your home have:</b>	<b>Do you use:</b>
<input type="checkbox"/> Stairs, No Railing	<input type="checkbox"/> Cane <input type="checkbox"/> Walker
<input type="checkbox"/> Elevator	<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Glasses
<input type="checkbox"/> Uneven Terrain	<input type="checkbox"/> Wheelchair: Motorized? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Stairs & Railing	
<input type="checkbox"/> Ramp	
<input type="checkbox"/> Assistive Devices	

Any Obstacles (describe) \_\_\_\_\_

**Have you had any major life changes during the past year?**  Yes  No  
(new child, job changes, death of a family member, move, marital status)

**How is your general health?**  Excellent  Good  Fair  Poor

**FAMILY HISTORY:** Indicate mother, father, brother, sister, aunt, uncle, grandmother, grandfather & age of onset

<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Other _____	

**What are your goals in coming to therapy today?** \_\_\_\_\_

**I would like to receive or discuss services with a social worker**  No  Yes  
I attest that, to the best of my knowledge, the above is true. I will notify the therapist of any changes.

Signed \_\_\_\_\_ Date \_\_\_\_\_