HEALTH HISTORY

To ensure you receive a thorough evaluation, please take the time to fill out this important medical form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name______________________________ Date of Birth:______________________________

Email address:____
(for internal use only)

Occupation: (past or present)____

Emergency Contact: Name________________________ Relationship____________________

Phone________________________ Alternate Phone________________

Whom may we thank for your referral? ____

Primary Physician: ____________________ Phone number:___________________________

Specialist: ___________________________ Phone number:___________________________

Are you under the care of any of the following? (Check all that apply):

( ) Medical Doctor (MD)	( ) Psychiatrist/Psychologist	( ) Personal Trainer
( ) Osteopath	( ) Physical Therapist	( ) Nutritionist
( ) Dentist	( ) Chiropractor	( ) Massage Therapist

If you have seen any of the above in the past three months, please briefly describe the reason *(illness, medical condition, physical, etc.)*: ______________________________________
____
____

Does your primary health practitioner know you are participating in physical therapy and/or Pilates?
YES NO

Have you had any prior experience with Pilates? YES NO

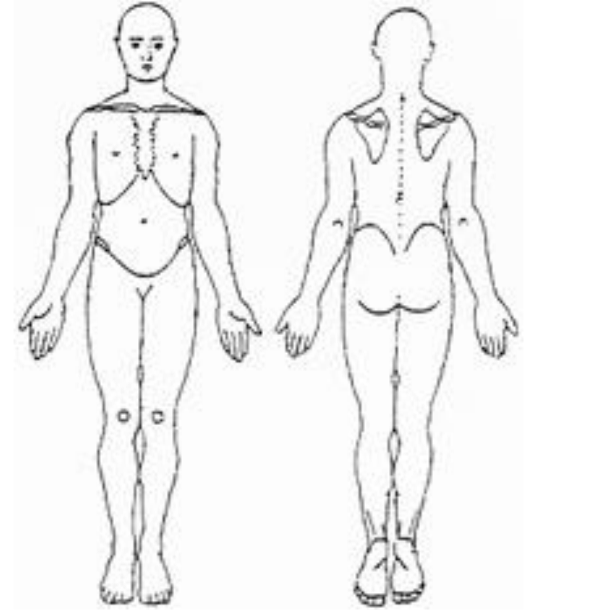
Describe the reason you are seeking physical therapy today: *(if related to trauma or injury please describe how it occurred)*: ____
____
____

What would a successful therapy outcome mean for you? *(walking the dog, playing golf, skiing…)*

1. ____
2. ____
3. ____

On a scale of 0-10, what is your energy level? ______________________
On a scale of 0-10, what is your pain level? ___________ Best? ______________ Worst?_________

Please indicate symptoms you are currently experiencing on the diagram below:



Do your symptoms make it difficult for you to sleep well? YES NO
(*circle all that apply*)

Difficulty falling asleep

Waking up due to pain

Difficulty returning to sleep

Describe your daily activities in terms of frequent positions *(circle those that apply)*

Sitting ***Standing*** ***Squatting***

Bending ***Twisting***

Reaching overhead

Other _________________________________

Do you exercise regularly? YES NO
If YES, how many days/week? _________________ Activities? _________________________________
____

How much water do you drink each day? ____

In the past 3 months have you had, or do you experience:

A general change in your health?	( )	Changes in appetite?	( )
Difficulty swallowing?	( )	Change in bowel/bladder function?	( )
Shortness of breath?	( )	Dizziness?	( )
Any type of infection?	( )	Nausea/ vomiting?	( )
Fever/ chills/sweats?	( )	Unexplained weight change?	( )
Numbness or tingling?	( )		

Which of the following over the counter medications have you taken in the last week?
(circle all that apply)

Aspirin	Tylenol	Laxatives
Advil/Motrin/Ibuprofen	Decongestants	Antihistamines
Antacid	Vitamins/minerals	Other: ______________________

Please list any PRESCRIPTION medications you are taking:

1. _________________________________ 2. ____

3. _________________________________ 4. ____

Past Medical History: Have you or any immediate family member *(parent, sibling, child)* ever been told you have:

	You	Family		You	Family

		Member			Member
Allergies			High Blood pressure		
Anemia			Joint replacement		
Arthritis or arthritic condition			Kidney disease		
Asthma, hay fever			Osteoporosis		
Lung or breathing problems			Peripheral Vascular Disease		
Cancer			Pacemaker		
Chemical dependency (alcohol/drugs)			Prostate Problems		
Circulation Problems			Shortness of breath		
Cirrhosis/liver disease/hepatitis			Stroke		
Diabetes			Skin Problems		
Depression			Thyroid problems		
Eating disorder			Varicose Veins		
Heart problems					

During the past month, have you been feeling down, depressed or hopeless? YES NO
During the past month have you had diminished interest or pleasure in doing things? YES NO
Please add any other disease or problem you have been treated for by a health care provider: ______________________________

Women: Are you (or could you be) pregnant? ______________________________
Number of children: ______________ Vaginal or Caesarian birth? *(circle)*

How many days per week do you drink alcohol? ______________________
Do you smoke? YES NO If YES how many packs/day?__________________

I understand the relationship I have with my physical therapist is a partnership. I have the right to ask questions regarding my treatment as well as refuse any part of treatment that has been recommended. My signature gives my consent to be treated.

______________________	______________________	__________
Patient Name	Signature	Date

______________________	__________
Practitioner	Date