



### 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: _____
Address: _____	
City: _____	State: _____ Zip: _____
Email address: _____ <i>(for internal use only)</i>	
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):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Medical Doctor (MD) | <input type="checkbox"/> Psychiatrist/Psychologist | <input type="checkbox"/> Personal Trainer  |
| <input type="checkbox"/> Osteopath           | <input type="checkbox"/> Physical Therapist        | <input type="checkbox"/> Nutritionist      |
| <input type="checkbox"/> Dentist             | <input type="checkbox"/> Chiropractor              | <input type="checkbox"/> 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 and/or Pilates today: (*if related to trauma or injury please describe how it occurred*): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

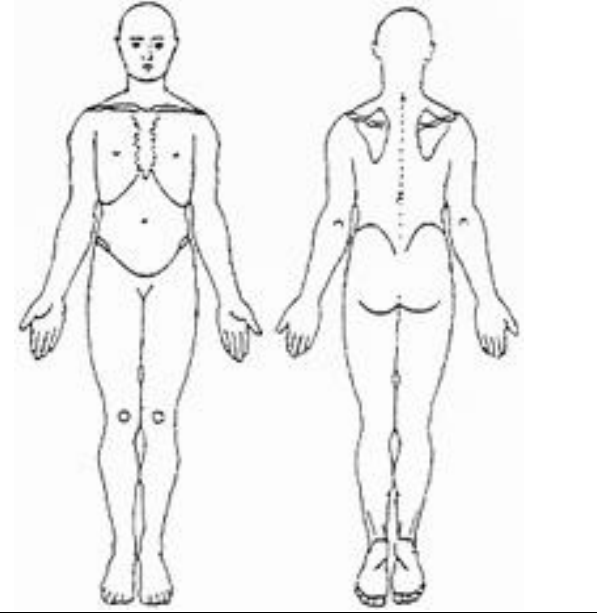
What would a successful therapy and/or Pilates outcome mean for you? (*walking the dog, playing golf, skiing...*)

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