



HEALTH HISTORY

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
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: _____

Is this visit related to an Auto accident, Work Comp, or lawsuit? YES NO

Explain: _____

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, briefly describe the reason (*illness, medical condition, physical, etc.*): _____

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

Have you had any prior experience with Pilates? YES NO

Have you had any recent injuries/surgeries/procedures/accidents in the past 12 months? Please explain.

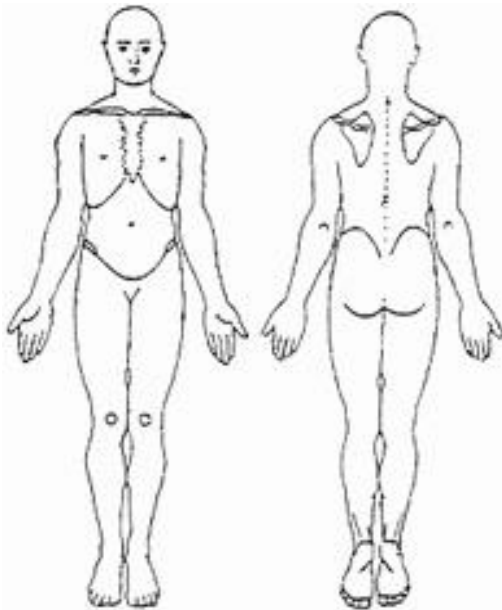
What would a successful therapy outcome mean for you? *(walking the dog, playing golf, skiing...)*

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?

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

Advil/Motrin/Ibuprofen

Antacid

Tylenol

Decongestants

Vitamins/minerals

Laxatives

Antihistamines

Other: _____

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 Member		You	Family Member
Allergies			High Blood pressure		
Anemia			Joint replacement		
Arthritis or arthritic condition			Kidney disease		
Asthma, hay fever			Osteoporosis/Osteopenia		
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					

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

In 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