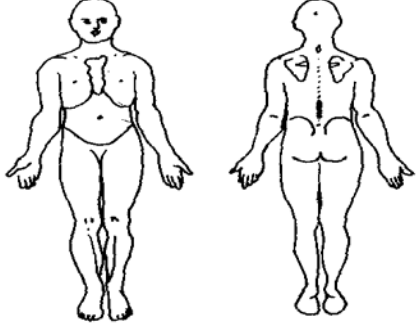


Apex Physical Therapy Specialists Health History

Name: _____ Age: _____

Reason for today's visit/Chief Complaint: _____

PRESENT INJURY/CONDITION

How did symptoms start?	<u>Please indicate area(s) of symptom on diagram:</u> Label: (P) Pain (N) Numbness	
When did this start?		
What makes symptoms worse?		
What makes symptoms better?		

On a scale of 0-10 (with 10 being severe pain) how would you rate your symptoms?

Please Circle: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

PAST MEDICAL HISTORY: Please indicate (Y) Yes or (N) No if you have had any of the following health concerns.

High Blood Pressure	Y	N	_____	Diabetes	Y	N	_____
Heart Trouble	Y	N	_____	Stroke	Y	N	_____
Respiratory Issues	Y	N	_____	Tuberculosis	Y	N	_____
Weakness of Muscles	Y	N	_____	Cancer	Y	N	_____
Joint Pain/Stiffness	Y	N	_____	HIV	Y	N	_____
Numbness/Tingling	Y	N	_____	Osteoporosis	Y	N	_____
Convulsions/Seizures	Y	N	_____	Tremors	Y	N	_____
Other	Y	N	_____	Head Injury	Y	N	_____

Previous Hospitalization/Surgeries/Serious Illness **When?**

Medication (include nonprescription)

FEMALE PATIENTS ONLY: Are you pregnant? Yes Due date _____ No

Patient Social History:

Do you have help at home: Yes: _____ No: _____
Alcohol Use Never: _____ Rarely: _____ Moderate: _____ Daily: _____ How Much? _____
Tobacco Use: Never: _____ Previously, but quit.(when) _____ Current Packs/day: _____

*** TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT AND ACCURATE.***

Patient Signature:

Date: