Heartland Women's Healthcare

PELVIS/BACK PATIENT HISTOY

Name: _____ **DOB:** _____ **Date:** _____

What is your main reason for coming to therapy? _____

_____

_____

Date this problem started? _____

How did this problem begin? _____

_____

Have you had these symptoms previously? ☐ Yes ☐ No **If yes, briefly describe your previous symptoms and/or treatment** _____

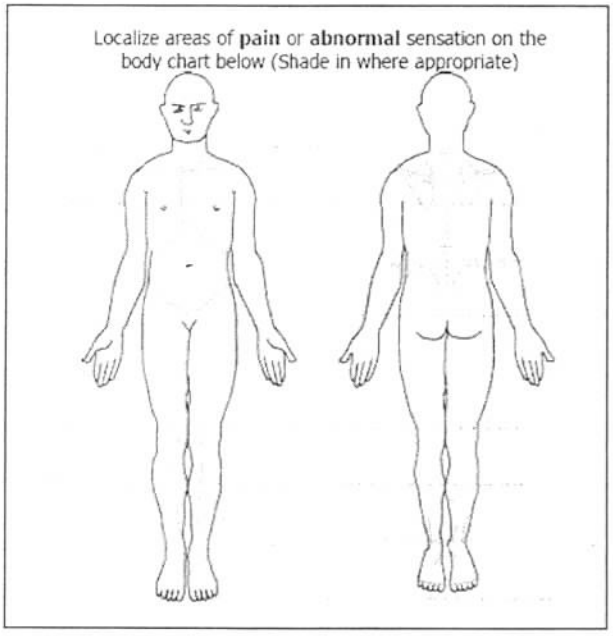
Shade in your pain area on the Body Chart and describe your pain:

Stabbing/Burning = Pins/Needles # Throbbing //

Numbness X Aching < Soreness > Sharp ||| Dull 0

Other: _____

_____



Please rate your pain intensity according to a 0-10 pain scale

(0-none 5-moderate 10- extreme agony)

Best: ___ Worst: _____ Average: _____ Now: ____

Pain worsens with: (circle all that apply): bending sitting standing lying rising am pm walking housework dressing turning lifting child care other: _____

_____

Pain improves with? bending sitting standing lying rising am pm walking moving resting exercise heat ice medication other: _____

Occupation/Activities: _____

Do you have any work or activity restrictions from your doctor? _____

_____

How does this problem affect your daily activities or work? _____

_____

Have you had any special tests for this condition? _____

What are your physical therapy goals? _____

Therapist Signature/Date: _____

Name: _____ **DOB:** _____

MEDICAL HISTORY

Medications : _____

_____

Drug/Food Allergies: _____

Are you pregnant?	**Yes/No** _____
Do you have a pacemaker/defibrillator?	Yes/No _____
Do you have any implanted device/metal?	**Yes/No** _____
Do you have a history of cancer?	Yes/No _____
Do you have any cardiac/heart problems?	**Yes/No** _____
Do you have cholesterol problems?	Yes/No _____
Do you have blood pressure problems?	**Yes/No** _____
Do you have diabetes?	Yes/No _____
Do you have osteoporosis/osteopenia?	**Yes/No** _____
Loss or changes in bowel/bladder control?	Yes/No _____
Do you have any respiratory problems?	**Yes/No** _____
Do you experience fever, sweats or chills?	Yes/No _____
Any unexplained weight loss?	**Yes/No** _____
Do you experience dizziness?	Yes/No _____
Any changes in your vision?	**Yes/No** _____
Do you have a history of falls?	Yes/No _____
Depression, anxiety, psychological issues?	**Yes/No** _____
Do you use glasses or hearing aides?	Yes/No _____
Do you have a latex allergy?	**Yes/No** _____

Please list any major surgeries, illnesses, injuries or past hospitalizations: _____

_____

_____

Are you currently receiving home health treatment? ☐ Yes ☐ No
Are you currently receiving chiropractic care? ☐ Yes ☐ No
Medicare patients - Have you received therapy since January? ☐ No ☐ Yes, # of visits _____
Medicaid patients - Have you received therapy since July? ☐ No ☐ Yes, # of visits _____
To the best of my ability, I have given and included all pertinent medical information.

Patient signature: _____ Date: _____

	Contact Physician if:
Blood Pressure_____	>160/90 or < 90/50
Resting Pulse Rate_____	> 100 or < 60 bpm
O2 Sats_____	< 90%

This medical history has been reviewed and used in determining the plan of care.

_____
Therapist Signature

_____ _____
Date Time