Family Physical Therapy

7 PARK AVENUE
COLCHESTER, CT 06415
P (860) 531-3222 **F** (860) 531-3224

3 WEYMOUTH RD
ENFIELD, CT 06082
P (860) 698-6308 **F** (860) 698-9658

HEALTH HISTORY

NAME: _____ **DOB:** _____

Are you in good health? Y / N
Are you currently taking any medications? Y / N
List Them:_____
_____
_____

Have you had any recent test (x-ray / MRI / Scans)? Y / N
List them: _____ Where? _____
Results:_____

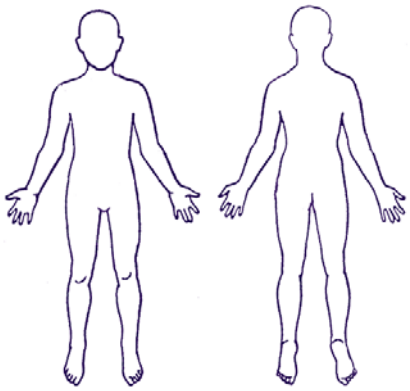
Are you currently being treated by any of the following? If so, please write name on line provided.

Medical Doctor Y / N _____
Osteopath Y / N _____
Chiropractor Y / N _____
Orthopedic Y / N _____
Other Y / N _____

Where is your pain located? Please mark the areas of pain on the diagram below using the pain key

Pain Key:

OOOO = Pins and Needles
XXXX = Burning
//// = Stabbing
----- = Dull Ache
PPPP = Other – Describe_____



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Do you have or have you ever been diagnosed as having any of the following?

Cancer	Y / N	(specify) _____			
Heart Problems	Y / N		High Blood Pressure	Y / N	
Asthma	y / N		Emphysema	Y / N	
Chemical Dependency	Y / N		Thyroid Problems	Y / N	
Diabetes I or II	Y / N		Multiple Sclerosis	Y / N	
Rheumatoid Arthritis	Y / N		Other Arthritic Conditions	Y / N	
Depression	Y / N		Hepatitis	Y / N	
Tuberculosis	Y / N		Stroke	Y / N	
Kidney Disease	Y / N		Anemia	Y / N	
Epilepsy	Y / N		Bleeding/Blood Disorder	Y / N	
Chronic Fatigue Syndrome	Y / N		Chronic Pain Syndrome	Y / N	
Fibromyalgia	Y / N		Liver Disease	Y / N	
Osteoporosis	Y / N				

Other Y / N (specify) _____
Other Neurological Conditions Y / N (specify) _____

Allergies

Are you allergic to tape? Y / N
Are you allergic to Latex? Y / N

Are you pregnant? Y / N
Have you recently lost/gained more than 10 pounds? Y / N
Are you experiencing any bowel/bladder irregularities? Y / N
Do you experience any numbness/tingling in hands or feet? Y / N
Do you experience any weakness in your legs or balance problems while walking? Y / N
Do you experience blurred vision, nausea, or difficulty breathing? Y / N

How many beverages containing caffeine do drink per day? _____
How many beverages containing alcohol do you drink per day? _____
How many packs of cigarettes do you smoke per day? _____

Please list a goal or goals for Physical Therapy:

_____
_____
_____