Intentional Wellness Physical Therapy, LLC

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Health History Questionnaire

First Name:_____MI_____Last Name_____

Address:_____

City:_____State:_____Zip Code:_____

Phone#:_____Work#:_____

Email Address:_____

Emergency Contact Person_____Phone#_____

Emergency Contact Persons relation to you:_____

***You have my permission to disclose my participation in PT to this Emergency Contact person for the purpose of emergency only.*

Male / Female	DOB:	DOI:	Height:	Weight:

Please list Licensed Health Care Providers you are currently working with:

Please ***initial*** for permission to release your Personal Health Information (PHI) to specific provider:

1) _____
_____You have my permission to release my PHI to this Health Care Provider.

2) _____
_____You have my permission to release my PHI to this Health Care Provider.

3) _____
_____You have my permission to release my PHI to this Health Care Provider.

Pre-existing conditions / Diseases / Prior Diagnoses / Surgeries:

_____
_____
_____
_____

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Health History Information on :_____

Current Medications and Dosages:

_____

_____

Describe Symptoms, Movements, Postures, or Concerns related to your current Problem

_____

_____

_____

_____

_____

_____

Circle ALL that apply whether from onset, or how you feel now:

Constant	**Burning**	**Cramping**	**Gnawing**	**Numbness**	**Apprehensive**
Tiring	**Kidnapping**	**Bullying**	**Alcoholism**	**Foreclosure**	**Betrayal**
Pinching	**Tingling**	**Worrisome**	**Tiring**	**Hot / Warm**	**Medicine Related**
Abortion	**Bankruptcy**	**Betrayal**	**Divorce**	**Adoption**	**Abandonment**
Frequent	**Stabbing**	**Aching**	**Radiating**	**Punishing**	**Cold / Cool**
Isolation	**Rape**	**Neglect**	**Assault**	**Poor**	**Intermittent**
Occasional	**Stinging**	**Throbbing**	**Tightness**	**Cruel**	**Helplessness**
Sharp	**Splitting**	**Sharp**	**Exhausting**	**Shocking**	**Sadness**
Heartbreak	**Arrested**	**Fired**	**Choking**	**Foreclosure**	**Weather Related**
Anger	**Dull**	**Fearful**	**Burdens**	**Shooting**	**Miscarriage**
Hit by Car	**Coming Out**	**Empty Nest**	**Death**	**Accident**	**Near Drowning**
Suicide	**Weight**	**Birth**	**Obesity**	**Threat**	**Substance Abuse**

Place a mark on this continuum indicating your present Pain/Symptoms

Comfortable = 0----------10 = Hospitalized

Health History Information on:_____

Vital Information:

Blood Pressure	@ rest:	During Exercise:
Heart Rate	@ rest:	During Exercise:
SAT's	@ rest:	During Exercise:
Body Temp	@ rest:	During Exercise:
Body pH		

Social / Health Habits:

Smoking?_____
Alcohol?_____
Recreational Drug use?
Amount of water I drink on a regular basis:_____
Amount of coffee I drink on a regular basis:_____
Amount of tea I drink on a regular basis:_____
Amount of soda I drink on a regular basis:_____
Hours of sleep I get on a regular basis:_____
Amount of stress in my life on a regular basis:_____
I live with:_____
I am allergic to:_____
My Occupation is:_____
What I know about my own birth: _____

I understand this and all other portions of my personal history and health information will be kept confidential as per the privacy policy standards I have signed, and according to the State Physical Therapy Practice Act unless otherwise indicated by myself.

X_____ **Date:**_____
Patient / Client Signature

Office Use Only

X_____ **Date:**_____
Physical Therapist Signature indicating all information on these forms read and reviewed with Patient/Client.

Revised 10/30/17