Columbia Gorge
Physical Therapy & Sports Medicine

PATIENT HEALTH HISTORY

Date: _____

Name: _____ **Age**: _____ **Gender: M / F**

Are you CURRENTLY under the care of any of the following? (Please check ALL that apply)

☐ Medical Doctor
☐Osteopath
☐ Acupuncturist
☐ Naturopath
☐ Chiropractor
☐ Massage Therapist
☐ Psychiatrist/Psychologist
☐ Other_____

Primary Care Physician: _____ **Referring Physician**: _____

Surgeries / Hospitalizations **Injuries** (fractures / dislocations / sprains)

Date	Type of surgery	Date	Type of injury
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any of the following conditions apply to your past or current state of health?

☐ Coronary Heart Disease
☐ Congenital Heart Disease
☐ Dizziness / Fainting
☐ Congestive Heart Failure
☐ Peripheral Vascular Disease
☐ Irregular Heartbeat / Murmur
☐ Infectious Disease
☐ Heart Attack
☐ Stroke
☐ Hernia
☐ Cancer
☐ Allergies
☐ Pregnant
☐ Asthma
☐ Diabetes
☐ Angina
☐ Pacemaker
☐ Emphysema
☐ COPD
☐ Epilepsy
☐ Eating Disorder
☐ Bowel / Bladder Problems
☐ Recent Weight Loss / Gain
☐ High Blood Pressure
☐ Shortness of Breath
☐ Systematic Disease
☐ Osteoporosis
Other _____

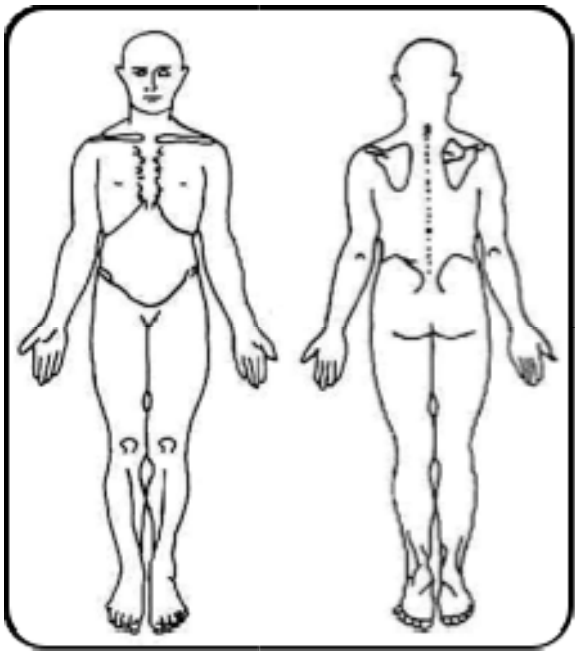
Since the onset of your CURRENT symptoms, have you had any of the following?

Bowel / Bladder dysfunction	**Yes**	**No**	Fever / Chills	**Yes**	**No**
Numbness in genital or anal area	**Yes**	**No**	Numbness	**Yes**	**No**
Dizziness or fainting	**Yes**	**No**	Weakness	**Yes**	**No**
Unexplained weight change	**Yes**	**No**	Night pain / sweats	**Yes**	**No**

Do you smoke cigarettes or use chewing tobacco?	**Yes**	**No**
Do you drink alcohol?	**Yes**	**No**
Do you drink coffee or caffeinated beverages?	**Yes**	**No**
Are currently taking any medications? (Please list below)	**Yes**	**No**

Medication Name:	Dosage:	Frequency:	Route of Administration: oral/Inhale/etc.)

Name: _____



Please indicate on the diagram where your pain is located and briefly describe your current symptoms: _____

_____

_____

Briefly describe your current condition (i.e. – chief complaint that brought you here?) _____

_____

Date of this injury? _____

_____

Has your pain gotten **better, worse or** stayed the **same** since it began? _____

Please circle your pain level below:

No pain — Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Describe your pain (sharp, dull, aching, tight, throbbing) _____

What makes your pain worse? (i.e. – lifting) _____

What makes your pain better? (i.e. – rest, movement) _____

How do you feel in the morning? (Please circle one) **Better** **Worse** **No Different**

How do you feel during the day? (Please circle one) **Better** **Worse** **No Different**

Has your sleep been interrupted by this pain? (Please circle one) **Yes** **No**

Have you had any of the following tests performed for this problem? ☐ X-ray ☐ MRI

☐ CT scan ☐ Bone Scan ☐ Arthrogram ☐ Lab Tests ☐ Other: _____

(If work related) Employer: _____ currently working: **Yes** **No**

Job Title: _____Work restrictions: _____

What are your expectations / goals of treatment? _____

For Office Use Only: Weight: _____ Height: _____

O2 Sat: _____ BP: _____mm/Hg Pulse: _____