Witte PHYSICAL THERAPY

PERSONAL HEALTH HISTORY

Name: _______________________________________ Height: __________ Weight: _________

Referring Physician: ____________________________________

What are we seeing you for today: _________________________________

How this injury occurred: ____

Where did this injury occur: _________________________ Date of Injury: ___ / ___ / _____

Where you treated in an emergency room: Yes No If Yes, Where: ____________________________

Have you had an X Ray or MRI: Yes No If Yes, Where: ____________________________

Are you currently Pregnant: Yes No

Do you smoke: Yes No If Yes, how many packs per day: _____________

Do you have any allergies: Yes No If Yes, please list: _______________________________________

Have you fallen in the past year: Yes No If Yes, how many times: ____________

If you have fallen, were you injured: Yes No
If Yes, please explain: ____

Have you recently or are you currently receiving home health care or physical therapy care: Yes No

Have you received physical therapy care in this calendar year: Yes No

Circle any you have or may have:

Arthritis Osteoarthritis Rheumatoid Arthritis Osteoporosis Epilepsy Diabetes

Kidney Disease Liver Disease Rheumatic Fever Cancer: ____________________________

Stomach Ulcers Cortisone Drugs Heart Disease Chest Pain Anemia

High Blood Pressure Stroke/TIA Depression Polio Tuberculosis Asthma

Chronic Bronchitis COPD/Emphysema Peripheral Neuropathy Diabetic Ulcer

Peripheral Artery Disease Other: ____

Past Surgeries (Year):

____

____

____

Medications:

Name: ___________________________ Dose: ______ Frequency: ________ Route: ______________
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