TRI CORE Physical Therapy

HEALTH HISTORY FORM

What treatment have you already received for your condition? ☐Medications ☐ Surgery ☐Physical Therapy ☐Chiropractic Services ☐ None ☐Other_____

Name of other doctor(s) who have treated you for your condition_____

Date of last: Physical Exam _____ Spinal X-ray _____
Spinal Exam _____ Chest X-ray _____
MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐YES ☐NO	Diabetes	☐YES ☐NO	Liver Disease	☐YES ☐NO	Rheumatic Fever	☐YES ☐NO
Alcoholism	☐YES ☐NO	Emphysema	☐YES ☐NO	Measles	☐YES ☐NO	Scarlet Fever	☐YES ☐NO
Allergy Shots	☐YES ☐NO	Epilepsy	☐YES ☐NO	Migraine Headaches	☐YES ☐NO	STD	☐YES ☐NO
Anorexia	☐YES ☐NO	Glaucoma	☐YES ☐NO	Mononucleosis	☐YES ☐NO	Stroke	☐YES ☐NO
Appendicitis	☐YES ☐NO	Goiter	☐YES ☐NO	Multiple Sclerosis	☐YES ☐NO	Suicide Attempt	☐YES ☐NO
Arthritis	☐YES ☐NO	Gonorrhea	☐YES ☐NO	Mumps	☐YES ☐NO	Thyroid Problems	☐YES ☐NO
Asthma	☐YES ☐NO	Gout	☐YES ☐NO	Osteoporosis	☐YES ☐NO	Tonsillitis	☐YES ☐NO
Bleeding Disorders	☐YES ☐NO	Heart Disease	☐YES ☐NO	Pacemaker	☐YES ☐NO	Tuberculosis	☐YES ☐NO
Breast Lump	☐YES ☐NO	Hepatitis	☐YES ☐NO	Parkinson's Disease	☐YES ☐NO	Tumors; Growths	☐YES ☐NO
Bronchitis	☐YES ☐NO	Hernia	☐YES ☐NO	Pinched Nerve	☐YES ☐NO	Typhoid Fever	☐YES ☐NO
Bulimia	☐YES ☐NO	Herniated Disk	☐YES ☐NO	Pneumonia	☐YES ☐NO	Ulcers	☐YES ☐NO
Cancer	☐YES ☐NO	Herpes	☐YES ☐NO	Polio	☐YES ☐NO	Vaginal Infections	☐YES ☐NO
Cataracts	☐YES ☐NO	High Blood Pressure	☐YES ☐NO	Prostate Problem	☐YES ☐NO	Whooping Cough	☐YES ☐NO
Chemical Dependancy	YES ☐NO	High Cholesterol	☐YES ☐NO	Psychiatric Care	☐YES ☐NO	Other:_____	
Chicken Pox	☐YES ☐NO	Kidney Disease	☐YES ☐NO	Rheumatoid Arthritis	☐YES ☐NO	_____	

EXERCISE

☐None
☐Moderate
☐Daily
☐Heavy

WORK ACTIVITY

☐Sitting
☐Standing
☐Light Labor
☐Heavy Labor

HABITS

☐Smoking Packs/Day_____
☐Alcohol Drinks/Week_____
☐Coffee/Caffeine Drinks Cups/Day_____
☐High Stress Level Reason_____

Are you Pregnant? ☐YES ☐NO Due Date:_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
_____
_____
Pharmacy Name:_____
Pharmacy Phone:_____

ALLERGIES

_____
_____
_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____
_____
_____

OTHER INFORMATION_____
_____
_____
_____