LaMarco Physical Therapy, P.C.

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Patient Health History

Name:_____ **DOB:**___/____/___ Prefer to be called:_____

Current Complaints/Injury?_____
_____

Date of onset? :_____ **Side:** Left / Right / NA

Did you have surgery? ☐ YES ☐ NO Date __/___/_____ Type: _____

What treatments have you received for this condition? (Injections, Chiropractor, splint, etc):
_____

Pain Type: Check all that apply: ☐ Burning ☐ Sharp ☐ Dull/Ache ☐ Other_____

Pain Level: Please indicate between 0-10: **Now**_____ **At Best**_____ **At Worst**_____
0 (No pain)----------5 (Moderate Pain)----------10 (Extreme Pain)

What makes your symptoms worse?_____
What makes your symptoms better? _____

Are you out of work due to this problem? ☐ YES ☐ NO When are you returning? _____

Diagnostic testing? ☐ YES ☐ NO If Yes please list below:

TEST	DATE	RESULTS

Additional Info:_____

_____

Patient Name_____ DOB_____

Height:___ft___in **Weight:**_____ **Blood Pressure**:___/___ **Occupation:**_____

PAST MEDICAL HISTORY: (Please check all that apply)

☐ Allergies	☐ CVA/Stroke	☐ Gout	☐ Parkinson's
☐ Alzheimer's	☐ Diabetic Type I/II	☐ Kidney Disease	☐ Polio
☐ Arthritis	☐ Defibrillator	☐ Liver disease	☐ Seizure Disorder
☐ Bone Loss	☐ Fibromyalgia	☐ Lupus	☐ Smoker
☐ Broken Bones	☐ Hearing Loss	☐ Metal Implants.	☐ Thyroid
☐ Cancer	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Vascular Disorder
☐ Cardiac	☐ HIV/AIDS	☐ Pacemaker	☐ Visual Loss

Explain above checked:_____
_____
_____

Are you currently on medication? ☐ Yes ☐ No. If yes please list below.

Medication	Dosage	Medication	Dosage

Past Surgeries: ☐ Yes ☐ No. If yes please list below.

Type of Surgery	Date
1.	
2.	
3.	
4.	