Confidential Health History

Elevate
Physical Therapy
and Performance

Name: _____ **Birthdate:** _____ **Date:** _____

Address:_____ **Cell:** _____

Emergency Contact: _____ **Phone:** _____

Occupation: _____ **Height:** _____ **Weight:** _____

Injury: _____ **Date of Onset:** _____

Other types of treatment for this condition (please circle): **PT Massage Chiropractor Specialist**

Rate your pain level: (0) = no pain; (10) = worst possible pain

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Best Pain in last week	0	1	2	3	4	5	6	7	8	9	10
Worst pain in last week	0	1	2	3	4	5	6	7	8	9	10

What makes your pain better? _____

What makes your pain worse? _____

List one important activity you are unable or have difficulty performing as a result of your pain/ symptoms (ex: stairs, reaching overhead) _____

My condition is: _____ getting better _____ getting worse _____ staying the same _____ unstable

List current medications: _____

_____

Are you currently taking blood thinning or anticoagulant medications? _____ **Yes** _____ **No**

List allergies: _____

Are you latex sensitive? _____ **Yes** _____ **No**

Women: Are you currently pregnant or think you might be pregnant? _____ **Yes** _____ **No**

List any surgeries or hospitalizations, with dates:

1. _____ 2. _____ 3._____

Have you RECENTLY noted any of the following (check all that apply)?

___ Changes in appetite
___ Changes in bowl or bladder function
___ Dizziness/light headedness
___ Difficulty swallowing
___ Difficulty maintaining balance while walking
___ Falls
___ Fever/chills/sweats
___ Headaches
___ Nausea/vomitting
___ Pain at night
___ Shortness of Breath
___ Weakness/fatigue
___ Weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

___ Anemia
___ Alzheimer's
___ Asthma
___ Cancer (type) _____
___ Chemical dependency/alcoholism
___ Concussion
___ Dementia
___ Depression
___ None
___ Diabetes
___ Epilepsy
___ Heart disease
___ High blood pressure
___ Kidney/liver problems
___ Lung problems
___ Multiple Sclerosis
___ Osteoporosis
___ Pacemaker inserted
___ Parkinson's disease
___ Rheumatoid arthritis
___ Stomach ulcers
___ Stroke
___ Thyroid problems
___ Traumatic Brain Injury
___ Other _____

Consent to Physical Therapy Evaluation and Treatment:

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist at Elevate Physical Therapy and Performance. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

_____ _____
Patient or Authorized Agent Signature Date

_____ _____
Relationship to patient (if other than patient) Patient Name Printed

Consent to Text and Email Communication:

I give Elevate Physical Therapy and Performance permission to contact me regarding my appointments and information regarding my treatment via:

___ email at address:_____ ___ text at cell number: _____

_____ _____
Patient or Authorized Agent Signature Date