Integrated Physical Therapy Services, Inc.

Health History / Review of Systems Form

Name: …… Date: ……

- **Have you ever had an allergic reaction to:** ☐ Lotion ☐ Perfume ☐ Gel ☐ Latex ☐ Adhesives

- **Have you ever been diagnosed or currently have any of the following conditions?** *Circle all that apply*

No	Yes	Cancer	No	Yes	Tuberculosis	No	Yes	Emphysema-Bronchitis
No	Yes	High blood pressure	No	Yes	Kidney disease	No	Yes	Asthma
No	Yes	Asthma	No	Yes	Kidney stone	No	Yes	Allergies, which? ……
No	Yes	Chemical dependency	No	Yes	Liver disease	No	Yes	Difficulty breathing
No	Yes	Rheumatoid arthritis	No	Yes	Seizure-Epilepsy	No	Yes	Breathing discomfort in positions
No	Yes	Depression	No	Yes	Osteopenia-Osteoporosis			other than upright
No	Yes	Dizziness-fainting	No	Yes	Heart problems	No	Yes	Sputum
No	Yes	Stroke	No	Yes	Circulation problems	No	Yes	Wheezing
No	Yes	Anemia	No	Yes	Blood clot	No	Yes	Thyroid problems
No	Yes	Incontinence	No	Yes	Heart palpitations	No	Yes	Multiple Sclerosis
No	Yes	Hernia	No	Yes	Chest pain	No	Yes	Other arthritic conditions
No	Yes	Mental health condition	No	Yes	Calf pain with walking	No	Yes	Autoimmune disorder
No	Yes	Frequent colds / flu	No	Yes	Abnormal EKG	No	Yes	Hepatitis
No	Yes	Numbness / tingling	No	Yes	High cholesterol	No	Yes	Diabetes
No	Yes	Fractures	No	Yes	Vision problems	No	Yes	Metal implant
No	Yes	Swelling of extremities	No	Yes	Insomnia	No	Yes	Hearing difficulty
No	Yes	Frequent falls	No	Yes	Migraines	No	Yes	Malaise
No	Yes	Frequent pain	No	Yes	Unexplained weight change	No	Yes	Night pain
No	Yes	Muscle spasms	No	Yes	Chronic-frequent cough	No	Yes	Night sweats-chills
No	Yes	Frequent sprain-strain	No	Yes	Weakness-fatigue	No	Yes	Bowel-bladder leakage
No	Yes	Stiffness	No	Yes	Nausea-vomiting	No	Yes	Pacemaker
No	Yes	Skin abnormalities	No	Yes	Ringing in your ears	No	Yes	Other:

- At present, how would you rate your overall health (circle what applies) Excellent Very Good Good Fair Poor

Exercise (circle what applies)		Work Activity (circle what applies)		Stress level (circle what applies)			Habits (circle what applies)
None	3-4x per wk	Sitting	Light labor				Smoking: …… packs per day
				Low	Medium	High	Alcohol: …… drinks per day
1-2x per wk	5+ x per wk	Standing	Heavy labor				Coffee-Soda: …… cups per day

- What things cause stress in your life? ……
- During the past month, have you been feeling down, depressed or hopeless? No Yes
- During the past month have you been bothered by having little interest or pleasure in doing things? No Yes
- If female, are you pregnant? No Yes

- Has anyone in your immediate family (parents, siblings) been treated for any of the following? (Circle all that apply)

Tuberculosis	Heart disease	Stroke	Alcoholism	Arthritis	Headaches	Mental Illness
Diabetes	High blood pressure	Kidney disease	Cancer	Anemia	Epilepsy	Other: ……

- Which of the following over the counter medications have you taken in the past week? (Circle all that apply)

Aspirin	Antacid	Tylenol	Antihistamines	Other: ……
Advil-Motrin-Ibuprofen	Decongestants	Laxatives	Vitamins / supplements	

- List any surgeries or injuries, including dates: ……..
  ……..
  ……..

- List all medications you are currently taking: ……..
  ……..

- Have you had this pain or condition before? No Yes (Circle what applies)
  If yes, did you receive any treatment? No Yes (Circle what applies)
  If yes, what type of treatment? ……..
  Did the treatment help? No Yes (Circle what applies)
  Have you had a related surgery? No Yes If yes, describe: ……..

- Have you had any imaging for your injury No Yes (Circle what applies)
  (Circle what applies) Xray MRI Bone scan CT Scan Ultrasound
  If yes, when did you have your imaging? ……..
  What were the results? ……..

- Have you had any work related injuries? No Yes (Circle what applies)
  If yes, list body part and date: ……..
- Have you had any auto accidents? No Yes (Circle what applies)
  If yes, list any injuries and date: ……..

- What is your occupation? (Circle what applies)

Professional / Executive	Laborer	Retired	White Collar / Secretarial
Homemaker	Tradesperson	Student	Other: ……..

  If not retired, a homemaker, or a student, what is your current work status? (Circle what applies)

Full time	Part-time	Off work	Unemployed
Self employed	Other: ……..		

- Have you had therapy before? No Yes (Circle what applies)
  If yes, what type? …….. For what? …….. Where? ……..

- My goals for therapy are: ……..

- Do you have any other conditions that we should be aware of? No Yes
  If yes, what? ……

- Is there anything else about you or your condition that you would like us to know? ……
  ……..

- How did you hear about us? (Circle all that applies)

My doctor referred me here	List provided by doctor	Phone book	Friend / Family; who? ……..
Insurance list	Website	Newspaper	Other: ……
Drove by / saw sign	Word of mouth	Television	

Thank you for taking the time for complete this paperwork. We will do whatever it takes to help you get better and improve your performance

Integrated Physical Therapy Services, Inc. **Symptom Assessment Form**

- Describe your symptoms / complaints: ……..
- When did your symptoms start?: ……...
- How did your symptoms begin? ……

- What increases your symptoms? ……
- What eases your symptoms? ……..
- Do you have symptoms at rest? No Yes (Circle what applies)
- Does your symptoms increase with activity? No Yes (Circle what applies)
- Does your pain decrease with activity? No Yes (Circle what applies)
- Is your condition? (Circle what applies) Getting Better Getting Worse Staying the Same

- Please indicate below where your symptoms are located

Use the symbols below to denote the location of symptoms on the body diagram

Ache	Pain	Stiff / Tight
********	######	++++++++
Numb	**Tingling**	**Shooting**
_ _ _ _	^^^^^^^^	>>>>>>

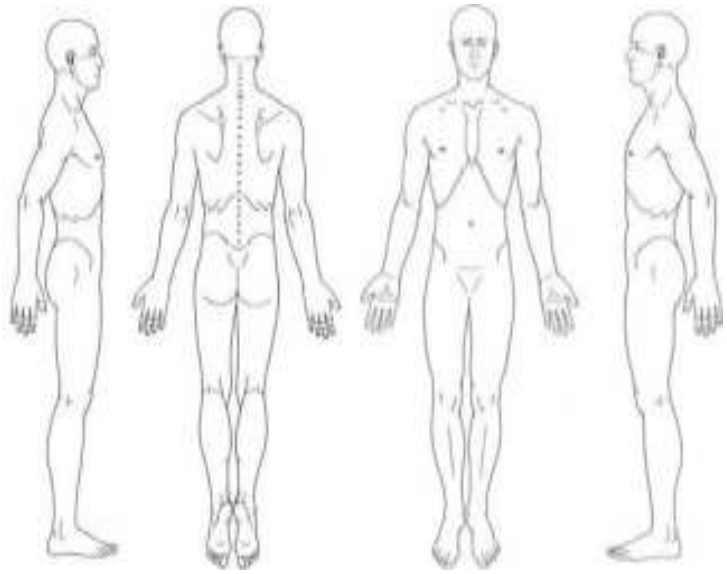
How often do you experience your symptoms?
(Circle what applies)

Intermittently
(0-25% of the time)

Occasionally
(26-50% of the time)

Frequently
(51-75% of the time)

Constantly
(76-100% of the time)



0 Pain free
1 Very minor annoyance, occasional minor twinges
2 Minor annoyance, occasional small twinges
3 Annoying enough to be distracting
4 Can be ignored if you are really involved in your work , but still distracting
5 Can not be ignored for more than 30 minutes
6 Can not be ignored for any length of time, but you can still go to work and participate in social activities
7 Makes it difficult to concentrate, interferes with sleep; can still function with effort
8 Physical activities severely limited; able to read, converse but only with effort
9 Unable to speak; crying out of moaning uncontrollably; near delirium

Some of the following words below describe your present pain. Circle ONLY those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category - the one that applies best

1 Flickering, Pulsing, Quivering, Throbbing, Beating, Pounding

2 Jumping, Flashing, Shooting

3 Pricking, Boring, Drilling, Stabbing

4 Sharp, Gritting, Lacerating

5 Pinching, Pressing, Gnawing, Cramping, Crushing

6 Tugging, Pulling, Wrenching

7 Hot, Burning, Scalding, Searing

8 Tingling, Itching, Smarting, Stinging

9 Dull, Sore, Hurting, Aching, Heavy

10 Tender, Taut, Rasping, Splitting

If you are having pain, please circle the number that best describes the following questions

Base your answers on the above guide

- What is your pain RIGHT NOW?

1 2 3 4 5 6 7 8 9 10

- What is your TYPICAL or AVERAGE pain?

1 2 3 4 5 6 7 8 9 10

- What is your pain AT ITS BEST?

1 2 3 4 5 6 7 8 9 10

- What is your pain AT ITS WORST?

1 2 3 4 5 6 7 8 9 10