Choice Therapy
Physical · Occupational · Speech

3835 Supreme Ct NW Suite 2
Bemidji, MN 56601
Phone: 218.444.8280
Fax: 218.444.8337
www.ChoiceTherapy1.com

CONFIDENTIAL HEALTH HISTORY

Name: _____ **Date:**_____

Primary Care Physician: _____

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Occupation: _____

Height: _____ Weight: _____

Reason for therapy appointment: _____

Date of onset: _____ **Description of onset**: _____

Other types of treatment for this condition (please circle):

Home Care Chiropractor Specialist Massage Other:_____

Have you lost any days of work? YES/NO If yes, explain? _____

Rate Pain Level (0) is no pain, (10) is 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 has been 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 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms: _____ (ex. Stairs, reaching overhead)

Over the last month my condition is: ☐ Getting better ☐ Getting Worse ☐ Staying the same ☐ Unstable

Any prior injuries? Yes No If yes, explain:

_____

Has a home care nurse been to your place within the last 60 days for blood pressure checks or medication set up? _____ If yes, which agency? _____

Please list current medications _____

_____

Are you currently taking blood thinning or anticoagulant medications for any medical condition? YES/NO

ALLERGIES: _____

Are you latex sensitive? YES/NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

I live at my own house (please check all that apply):

- ☐ Independently
- ☐ With strong local support
- ☐ With limited/no local support
- ☐ I am a caregiver
- ☐ I am not living in my own house

Do you have an Advanced Directive stating "Do not resuscitate"? YES/NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES/NO

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

- ☐ Changes in appetite
- ☐ Changes in bowel or bladder function
- ☐ Dizziness/light headedness
- ☐ Difficulty swallowing
- ☐ Difficulty maintaining balance while walking
- ☐ Falls
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Nausea/vomiting
- ☐ 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 _____

Patient Name (printed): _____

Patient Signature: _____ **Date:** _____