SOUND BODY REHABILITATION INC
BUILDING A BETTER YOU

HEALTH & HISTORY

Patient name _____ Today's date _____

Date of birth _____ Age _____

Referring doctor/provider _____ Phone _____

Primary doctor/provider _____ Phone _____

1. Please briefly describe the problem that brought you here _____

_____

2. When did your problem first begin? _____ months ago, or _____ years ago.

3. Is this problem related to a specific accident? Work? _____ Auto? _____ Date of injury _____

4. Since that time is it: staying the same _____ getting worse _____ getting better _____

5. Describe previous treatment/exercises _____

6. What are your treatment goals or concerns?_____

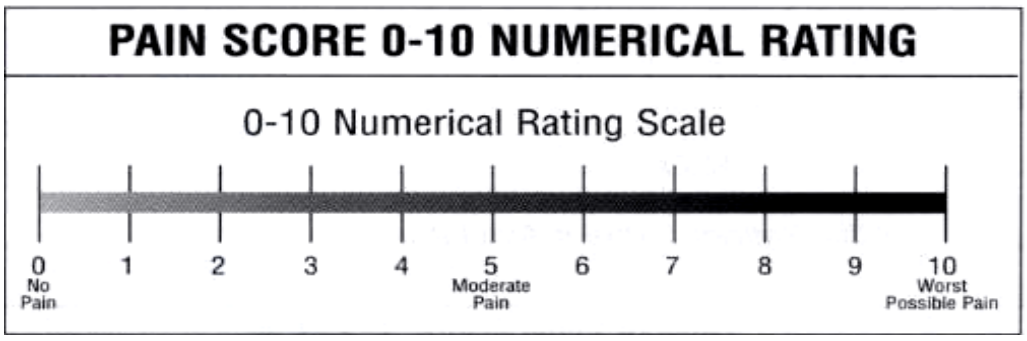
_____

7. Describe the nature of your symptoms (i.e. constant burning pain, intermittent ache, tingling) _____

_____

8. Where is your pain or other symptoms? _____

9. Numerical rating scale (NRS) Please indicate your average level of pain on the scale below.



Since the onset of your current symptoms have you also had:

Y/N Fever/chills	Y/N Malaise (Unexplained tiredness)	Y/N Blurred vision
Y/N Unexplained weight change	Y/N Unexplained muscle weakness	Y/N Memory loss
Y/N Dizziness or fainting	Y/N Night pain/sweats	Y/N Depressed mood
Y/N Change in bowel or bladder functions	Y/N Numbness / tingling	Y/N Ringing in ears

Y/N Other /describe _____

General Health: Excellent _____ Good _____ Average_____ Fair_____ Poor_____

Health History: Date of Last Physical Exam _____

Tobacco use: Current smoker? Yes _____ No _____ How many years? _____

Alcohol use: Yes _____ No _____

Height _____ **Weight** _____

Falls: How many times have you fallen in the last 12 months?_____

Were you injured in any of these falls? _____

What is your occupation? _____

Have you ever had any of the following conditions or diagnoses? Circle all that apply /describe

Cancer/Type _____

Stroke	Emphysema/chronic bronchitis	Asthma
Heart problems	Epilepsy/seizures	Allergies-list below
High blood Pressure	Multiple sclerosis	Latex sensitivity
Ankle swelling	Head injury	Anemia
Osteoporosis	Hypothyroid/ hyperthyroid	Headaches
Low back pain	Chronic Fatigue	Sacroiliac/tailbone pain
Fibromyalgia	Diabetes	Kidney disease
Alcoholism/drug problem	Arthritis	Depression
Rheumatoid arthritis	Hepatitis	HIV/AIDS
Anorexia/bulimia	Joint replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or sexual abuse
Vision/eye problems	Sports Injuries	Reynaud's (cold hands and feet)
Hearing loss/problems	TMJ	Bursitis
Neck pain	Pelvic pain	Blood clots
Cardiac Pacemaker/defib	Implant insulin pump	Implant stimulator/brain
Incontinence	Respiratory disease	Low blood sugar
Other _____		Anxiety/PTSD
Other_____		

Surgical/procedure history: List procedures and dates

_____

_____

_____

_____

Please list all current medications, vitamins, supplements

Medications	Dosage	Frequency	Pills/Injections/Patch?