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) _____________

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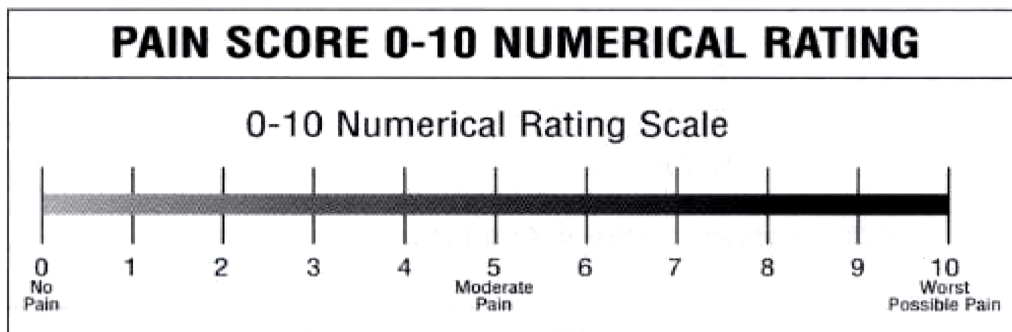
8. Where is your pain or other symptoms? ____

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

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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?