MEDICAL HISTORY

Patient Name: ______________________
Date of Birth: ______________________
Today's Date: ______________________

What are your weight and height? ______________________
Do you have any heart problems? ______________________
Do you have any breathing issues, like Asthma? ______________________
Do you have any problems with bowel or bladder control? ______________________
Are you experiencing vision or hearing problems? ______________________
Any circulation or limb problems? ______________________
Have you broken any bones? ______________________
Have you had any surgeries or medical procedures? ______________________
____

Any medical conditions, such as diabetes or bronchitis, that will affect your ability to participate in therapy? ______________________
____

Are you or could you be pregnant? ______________________

List any Medications: ______________________
____
____
____
____

Circle the Activities are you having difficulty doing?

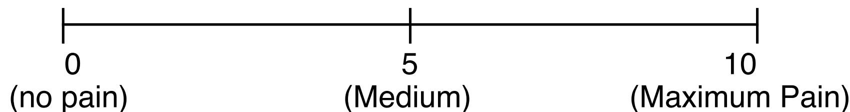
Stairs	Standing	Sitting	Getting Dressed
Kneeling	Crawling	Walking	Getting up from Toilet

Are you having any problems combing your hair? ______________________
Are there any problems with driving? ______________________
Do you have difficulty sleeping? ______________________

Do you have any limitations?

Reaching   Carrying   Lifting

If you have pain, how would you rate it on a scale of 0-10?



HENNIKER PHYSICAL THERAPY