

TREVILLIAN PHYSICAL THERAPY & PELVIC HEALTH

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Patient Health History Form

Patient Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **Referring Provider:** _____

Currently working? Yes or No _____ **Occupation:** _____

Reason for Physical Therapy: _____

When did this problem start? _____

Did a specific incident cause it? If yes, please describe: _____

Are your symptoms _____ **staying the same,** _____ **getting better,** _____ **getting worse?**

Have you had physical therapy in the past for these symptoms? Yes or No (circle)

What are your goals for Physical Therapy? _____

Medications (include reasons and supplements): _____

Allergies: _____

Since the onset of your current symptoms have you had:

Y/N Fever/Chills

Y/N Malaise (Unexplained tiredness)

Y/N Unexplained weight change

Y/N Unexplained muscle weakness

Y/N Dizziness or fainting

Y/N Night pain/sweats

Y/N Change in bowel or bladder functions

Y/N Numbness / Tingling

Other /describe: _____

Please indicate if you are experiencing or have experienced any of the following:

	Anemia		Hearing Loss		Osteoporosis
	Arthritis		Hepatitis		Pacemaker
	Asthma		High Blood pressure		Pelvic Pain
	Blood Disorders		HIV/AIDS		Physical Abuse
	Cancer		Hypo/Hyperthyroid		Sexual Abuse
	Depression		IBS		STD's
	Diabetes		Interstitial Cystitis		Stroke
	Epilepsy/Seizures		Kidney Disease		TIA
	Head Injury		Low back pain		TMJ
	Headaches		Neck pain		Vision Problems

If you are experiencing pain, please indicate your pain level below:

0 _____ 10
0= no pain 10=ER Visit

How would you describe your pain? (circle all that apply)

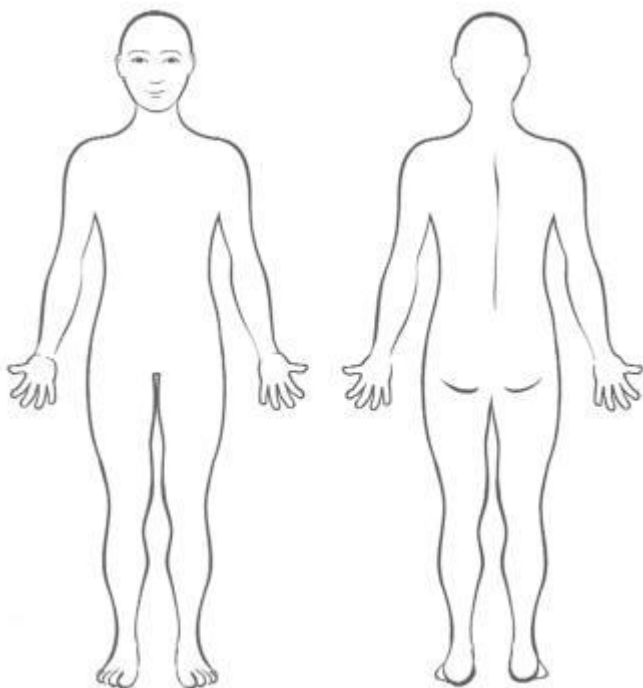
Aching Stabbing Shooting Sharp Dull
Constant Tingling Intermittent Pressure Numb

Other: _____

What increases your pain? _____

What decreases your pain? _____

Indicate where you are having pain below:



Front

Back

Please indicate your stress level below:

_____ 10= extreme stress
0=no stress