



Desert Physical Therapy
 & Women's Health Center, LLC
 4545 E. Shea Blvd. Suite 168
 P: (602)264-3369

GENERAL HEALTH HISTORY:

NAME: _____

DATE: _____

Reason for physical therapy: _____

Please list any current medications and/or allergies: _____

Please indicate if you have or have had any of the following:

Condition	Yes	No	Describe/When
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart/Lung	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle, Joint, Bone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary/Gynecologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

Surgery	Yes	No	Describe/When
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uterine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Plastic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

For Women Only:

Vaginal delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Caesarian delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menopausal changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when is your due date: _____

Please indicate your level of pain below:

_____ 0 10
 No Pain ER Visit

Please indicate your level of stress below:

_____ 0 10
 No Stress Extreme Stress