ACTIVE PLUS PHYSICAL THERAPY

Health History Form

Confidential — shared only with your care team.

CURRENT SYMPTOMS

DESCRIBE YOUR SYMPTOMS AND WHERE YOU FEEL THEM

PAIN RIGHT NOW (0–10)

WORST PAIN IN PAST WEEK (0–10)

PATTERN

- ☐ Constant
- ☐ Comes and goes
- ☐ Worse in morning
- ☐ Worse at night
- ☐ Worse with activity
- ☐ Better with rest

ALSO EXPERIENCING

- ☐ Numbness / tingling
- ☐ Weakness
- ☐ Swelling
- ☐ Dizziness
- ☐ Headaches
- ☐ Balance problems

MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Pacemaker / implant
- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Cancer (current/past)
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Lung disease / asthma
- ☐ Kidney disease
- ☐ Neurological condition
- ☐ Depression / anxiety
- ☐ Pregnant / may be pregnant
- ☐ Bladder / bowel issues
- ☐ Blood clots
- ☐ Lymphedema
- ☐ Other

PLEASE EXPLAIN ANY ITEMS CHECKED ABOVE

SURGERIES, INJURIES & IMAGING

PAST SURGERIES (TYPE AND YEAR)

PAST INJURIES, FRACTURES OR RECENT X-RAY / MRI RESULTS

MEDICATIONS & ALLERGIES

CURRENT MEDICATIONS AND SUPPLEMENTS

ALLERGIES (MEDICATIONS, LATEX, OTHER)

HEIGHT / WEIGHT (OPTIONAL)

LIFESTYLE

OCCUPATION

WORK DEMANDS (SITTING, LIFTING, STANDING…)

EXERCISE / ACTIVITIES

HAND DOMINANCE (L / R)

I confirm that the information above is accurate to the best of my knowledge. I will inform my therapist of any changes in my health.

PATIENT (OR GUARDIAN) SIGNATURE

DATE