

## Health History Form

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**What is the reason for your visit today?** \_\_\_\_\_

**Briefly describe how your problem began:** \_\_\_\_\_

**When did your problem begin?** \_\_\_\_\_

**What is your biggest goal for therapy?** \_\_\_\_\_

**How would you rate your current health?** EXCELLENT    VERY GOOD    GOOD    FAIR    POOR

**Please circle yes or no if you have or have had any of the following conditions:**

Smoke / chew tobacco -packs / day: _____	Y / N	Diabetes	Y / N	Lupus	Y / N
Use of illegal substances	Y / N	Heart Attack	Y / N	Fibromyalgia	Y / N
Drink alcoholic beverages - amt / day: _____	Y / N	Cardiac Bypass	Y / N	Osteoarthritis	Y / N
High Blood Pressure	Y / N	Pacemaker	Y / N	Rheumatoid Arthritis	Y / N
High Cholesterol	Y / N	Angina / Chest Pain	Y / N	Osteoporosis or Osteopenia	Y / N
Bowel / Bladder Dysfunction	Y / N	Hepatitis	Y / N	Scoliosis	Y / N
Acid Reflux or Ulcers	Y / N	Emphysema	Y / N	Sexually Transmitted Disease	Y / N
Thyroid Disorder	Y / N	COPD	Y / N	Multiple Sclerosis	Y / N
Bleeding Disorder	Y / N	Asthma	Y / N	Cancer (site: _____)	Y / N
Seizures / Epilepsy	Y / N	Kidney Disease	Y / N	Recent Infection	Y / N
Lyme Disease	Y / N	Stroke	Y / N	Headaches or Migraines	Y / N
Pregnant (# weeks _____)	Y / N	Congestive Heart Failure	Y / N	Dizziness or Fainting	Y / N
Chronic Pain	Y / N	Anxiety	Y / N	Depression	Y / N

Additional Details:

\_\_\_\_\_

Please list all medications / supplements you currently take.

\_\_\_\_\_

List all allergies you may have: \_\_\_\_\_

List all previous surgeries and / or injuries and dates:

\_\_\_\_\_

**To the best of my ability, I have given and included all pertinent medical information.**

**Client / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health History reviewed by physical / occupational therapy student and used in determining plan of care.**  
**Student Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Licensed Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_