MISSOULA Bone & Joint Physical Therapy & Sports Medicine

Health History

Name: _____ Birthdate: _____ Age: _____

Preferred Name / Nickname:_____

Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left Gender: ☐ Male ☐ Female

Phone Number: _____ Email: _____

Occupation: _____ Referring Provider: _____

Past Medical History:

☐ Heart Trouble	☐ Arthritis	☐ Bleeding Disorders	☐ Stomach Ulcer
☐ High Blood Pressure	☐ Seizures	☐ Lung Disease	☐ Liver Disorder
☐ Stroke	☐ Sleep Apnea	☐ Asthma	☐ Thyroid Disorder
☐ Diabetes	☐ Kidney Trouble	☐ Phlebitis	☐ Cancer
☐ Gout	☐ Osteoporosis	☐ Anemia	☐ Aids/HIV
☐Pacemaker	☐ Other: _____		

Known Allergies:_____

Please List all current medications, supplements or vitamins:_____

_____

_____

Reason for Today's Visit: _____

Which Side: R / L both Date Problem Began: _____

How did your injury occur? _____

What has helped the pain? _____

What makes the pain worse? _____

In the past 24 hours, what is the **worst** your pain has been? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

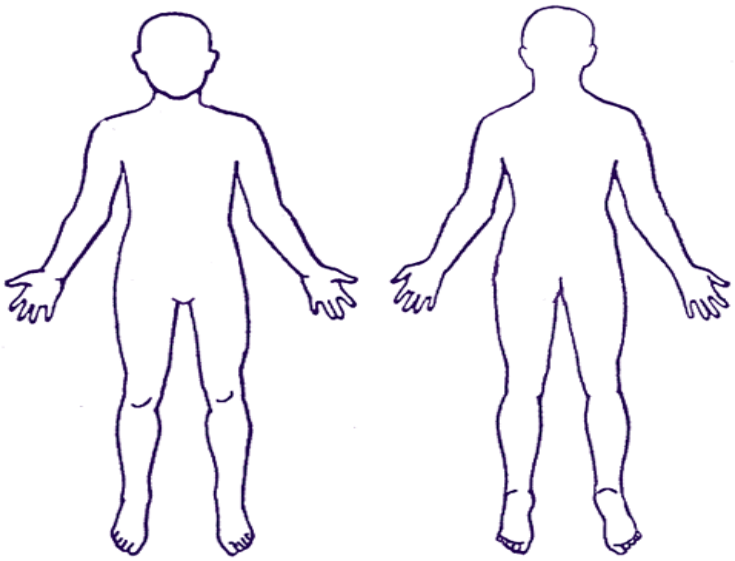
In the past 24 hours, what is the **least** your pain has been? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Previous Surgeries:_____

_____

_____

Where is Your Pain Now?



Mark an "S" on sharp pain; # on burning; and X on dull pain where you are currently experiencing symptoms.

Functional Limitation:

Prior level of function: _____

Work requirements: _____

Are you having difficulty with any of the following?

Walking and moving around: _____

Changing Body positions: _____

Carrying, moving or handling objects: _____

Self-care: _____

Other limitations (hobbies, sports, recreational activities):_____

Social History:

☐ Married ☐Single Do you live alone? ☐ Yes ☐ No If no, who do you live with?_____

Home environment / barriers? _____Stairs?_____ (how many)_____

How many times per week do you get 30 minutes of moderate physical activity? 1-2 2-3 3+

Have you fallen in the past year? Y / N injury?_____

Wellness/Nutrition:

Describe your typical eating habits:_____

Have you ever struggled with your weight (gaining or losing)?_____

Do you struggle with appetite, poor injury/wound healing, or any digestive issues?_____

Would you like a referral to our Registered Dietitian to talk about nutrition?_____