Wellness Works Physical Therapy
Santa Fe, NM

Patient Medical History Form

Name:_____DOB:_____

Personal Health History Questionnaire								
Please check yes for any conditions you have had.								
	Yes	No		Yes	No	Have you recently noticed		
Diabetes			Asthma				Yes	No
High cholesterol			COPD			Nausea/vomiting		
High blood pressure			Bronchitis			Fatigue		
Low blood pressure			Heart disease			Weakness		
Dizziness			Pacemaker			Fever/chills/sweats		
Osteoporosis/Osteopenia			Cancer			Frequent falls		
Osteoarthritis			Recent Weight loss			Other:		
Rheumatoid arthritis			Stroke/CVA/TIA					
Visual Changes			Hearing changes					
Depression			Cancer					
Bowel changes			Head injury					
Bladder changes			Hyperthyroid					
Vascular disease			Hypothyroid					
Numbness tingling			Difficulty swallowing					
Difficulty speaking								

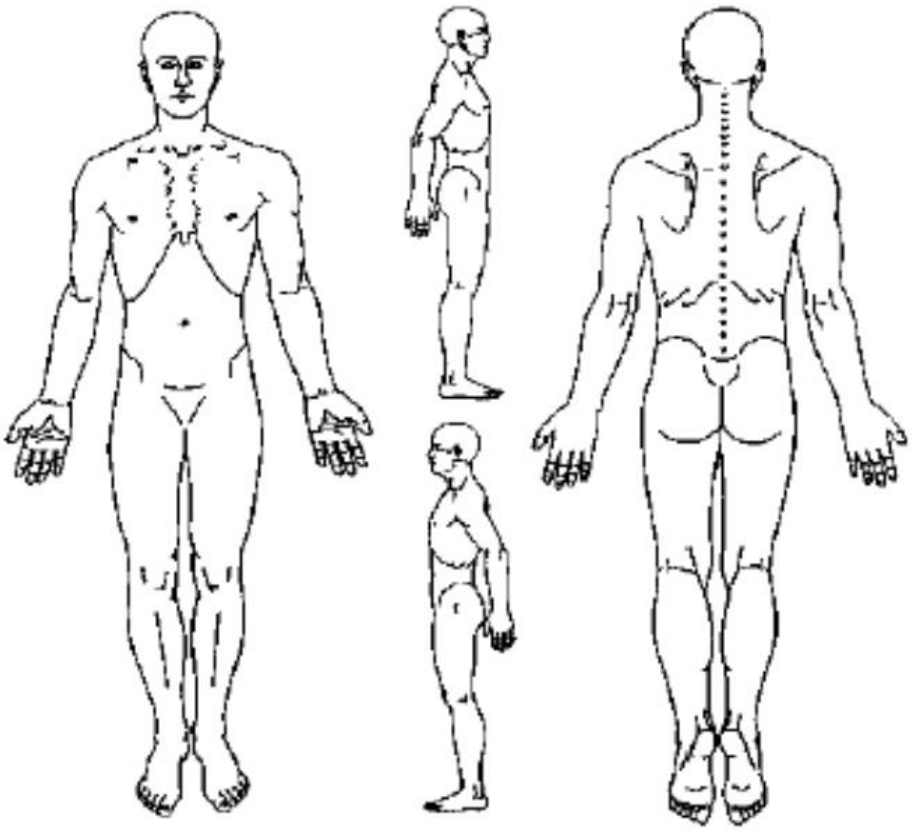
Please list any other medical problems and Orthopedic injuries

Surgeries/Hospitalizations	
Year	Reason

Imaging: X-rays/MRI etc.

Personal Health habits	
The following questions are strictly confidential and optional	
Exercise:	☐ Sedentary (no exercise)
	☐ Mild (walking three blocks, climbing stairs)
	☐ Occasional vigorous exercise (<4x/week for 30 minutes)
	☐ Regular vigorous exercise (4x/week for 30 minutes)

Name:_____DOB:_____



Please Rate you pain using the following scale:

At rest:_____ Best: _____
Worst:_____
What increases your pain?_____

_____

What decreases you pain?_____

_____

Describe your pain?_____

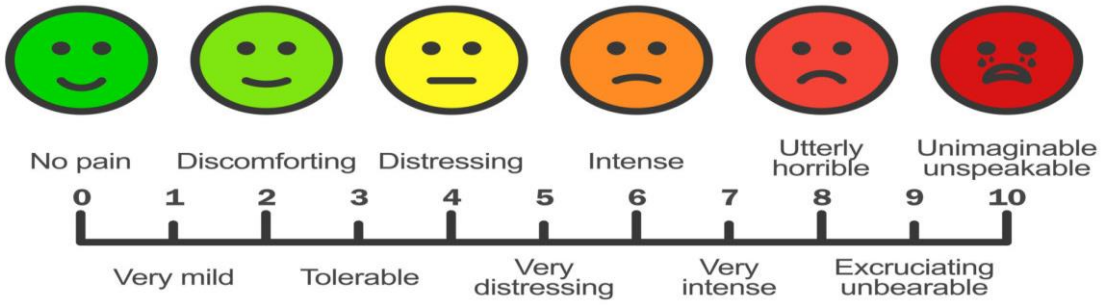
_____

Indicate on the chart where you have symptoms:

xx = pain

// = tingling or burning

= numbness



Activity Information	
Please list any activities which are limited by this injury	
Goals	
What is your goal for physical therapy?	