TEMP: ________ BP_______________
LASER: Yes / No
LB ___________ Auth Visits _________
HT ___________ MD _______________
BMI __________ BP _______ / _______
HR ___________ O2 _______________

INSURANCE___________________________
(notes) ______________________________

New Patient Health History Form

Name:________________________________ Age:_____ Place of Employment ______________________

Referring Physician: _____________________________________ Phone: _________________________

Primary Care Physician: __________________________________ Phone: _________________________

List any other doctors you are being treated by (ie: Cardiologist, Orthopedic, Neurologist, Pain Management):

____ ____

____ ____

How did you hear about Troxell Physical Therapy? (Please check)

Physician Referral___ Yellow Pages___ Fresno Bee___ Website___ Friend (Name)______________________

Other **(Please explain)**_____________________________________

Dominant Hand **(circle)**: Right or Left Sex **(circle)**: Male or Female

When did your condition occur? **(Date)**____

If this is an injury, how did it happen?____

____

What body parts are currently affected?____

When did your symptoms begin occurring? **(Please check)** Immediately?____ Gradually?____

Since this condition began are your symptoms: Increasing___ Decreasing___ No change___

How much of the day do you feel your symptoms?

Occasional (10-25%)___ Intermittent (26-50%)___ Frequent (51-89%)___ Constant (90-100%)___

Choose below which most accurately describes your symptoms:

___ Pain is annoying but able to perform all activities.
___ Pain is tolerated but may cause difficulty performing some activities.
___ Pain interferes with performance of all activities.
___ Pain is so severe that you are unable to perform any activity.

How are you sleeping at night? Good___ Fair___ Poor___

What makes you condition feel worse?

Nothing___ Sitting___ Standing___ Walking___ Running___ Stairs___ Kneeling___ Bending___
Twisting ___ Lifting___ Writing___ Typing___ Other:_______________________________________

What makes your condition feel better?

Nothing___ Lying Down___ Sitting___ Walking___ Stretching___ Movement___ Exercise___
Manipulation___ Medication___ Other:____

What treatments have you already received for this condition?

None___ Physical Therapy___ Surgery___ Chiropractic___
Diagnostics Tests: CT Scan___ EMG/NCV___ MRI___ X-Ray___
Name of facility:____

What medications are you currently taking?

1.____ x day (circle) am/pm
2.____ x day (circle) am/pm
3.____ x day (circle) am/pm
4.____ x day (circle) am/pm
5.____ x day (circle) am/pm
6.____ x day (circle) am/pm

Hobbies/Activities:____

Are you currently working? Yes___ No___ If no, last date worked:___________________________________

Do you have any work limitations? Yes___ No___ If yes, limitations:__________________________________
____

How would you describe your overall health? Poor___ Fair___ Good___ Excellent___

Do you have any of the following? High Blood Pressure___ Diabetes___ Heart Disease _____ Cancer______

Rate your current pain: **(circle one)** Low 1---2---3---4---5---6---7---8---9---10 High

Mark on the picture below where you have pain or symptoms:

// = numbness

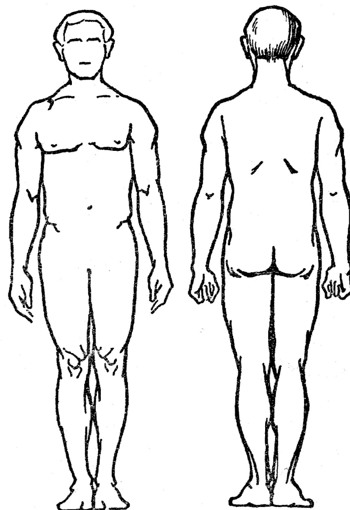
.. = burning

^ = tingling

~ = pain

xx = ache

ss= soreness



Patient /or Parent: ____ Date: ______________________
Signature