Patient Name:_____

GAMBRILL'S PHYSICAL THERAPY

HISTORY FORM

CURRENT CONDITION/CHIEF COMPLAINT

Describe why you are seeking physical therapy? _____
_____
_____
When did it begin? _____
Was there an injury? _____
How is the problem affecting your life? _____
_____
What aggravates your symptoms? _____
How do you relieve your symptoms? _____
What are your functional goals with therapy? _____

Please list any **MEDICATIONS** including over the counter medications that you are currently taking:

_____
_____
_____
_____
□See Copy_____
ALLERGIES:_____
SURGICAL HISTORY Date
_____
_____
_____

CPR

Have your completed an advance directive for DNR (Do not resuscitate) which indicates no cardiopulmonary resuscitation (CPR) if you heart stops or if you stop breathing? □ YES □NO
If answered yes, please provide facility with copy of advanced directives.

SOCIAL/HEALTH HABITS

What is your occupation? _____
How many cups of caffeine do you consume a day? _____
How many cigarettes do you smoke a day? _____
How much alcohol do you drink a day? Week? _____
How many days a week do you exercise? _____
What type of exercise do you do? _____
Marital Status _____
Home Environment: Home/Apartment ___#Steps to enter ___#Steps to 2nd floor
Are there any religious/cultural beliefs that may affect your care that we should be aware of?
_____
_____
Are you currently seeing anyone else for your condition?
□Acupuncturist □Chiropractor □Massage Therapist □Family Practitioner □Cardiologist □Orthopedist □ Podiatrist □Internist □Neurologist □Rheumatologist □Psychologist □OB/GYN □Pediatrician □ _____
EMAIL ADDRESS: _____
□ I give Gambrill's Physical Therapy permission to email me regarding my physical therapy care as well as upcoming events and newsletters.

Patient Name:

PAST MEDICAL HISTORY

(please check if you have or have had any of the conditions)

□Heart Problems_____	□Chemical Dependency	□Infectious Disease
□Stroke	□Depression	□Skin Disease
□High Blood Pressure	□Anxiety Disorder	□Head Injury
□Kidney Problems	□Multiple Sclerosis	□Peripheral Vascular Disease
□Seizures/Epilepsy	□Parkinsons Disease	□Lymphedema
□Osteoporosis/Osteopenia	□Anemia	□Cancer_____
□Asthma	□Blood Disorder	□Prostate Disease
□Emphysema	□Stomach Ulcers	□High Cholesterol
□Hepatitis	□GERD	□Diabetes_____
□Rhematoid Arthritis	□Osteoarthritis	□_____

Last MD Physical Examination: _____(Date)

FAMILY PAST MEDICAL HISTORY

□Cancer	□Stroke	□Psychological
□Heart Conditions	□Diabetes	□Hypertension
□Arthritis	□Osteoporosis	□_____

IF YOU HAVE NOT BEEN DIAGNOSED WITH A CONDITION AND/OR STILL HAVING SYMTPOMS then please check if you have any of the following symptoms:

Gastrointestinal
□Difficulty Swallowing
□Heartburn
□Jaundice (yellow appearance)
□Specific Food Intolerance
□Constipation
□Diarrhea
□Change in Color of Stool
□Rectal Bleeding
□Gall Bladder Problems
□Liver Problems

Pulmonary
□Dyspenea (labored breathing)
□Wheezing
□Prolonged Cough
□Sputum Production

Endocrine
□Excessive Thirst
□Excessive Hunger
□Excessive Sweating
□Polyuria (large volume of urine)
□Fatigue
□Thyroid Problem

Other
□ _____
□_____

Cardiovascular
□ Sweat associated with pain
□Palpitations
□Swelling of Extremities
□Smoking
□Difficulty Breathing (orthopenea)

Urological/Gynecological
□Dysuria (painful urination)
□Hematoria (blood in urine)
□Incontinence
□Increased Frequency of urination
□Vaginal Discharge
□Post Menopausal Vaginal Bleeding
□Painful Intercourse
□Infertility
□History of STD

Neurological
□Ataxia
□Memory Lapse
□Confusion
□Head Trauma
□Neurological Disorder
□Tremors
□Slurred Speech
□Hearing/Visual Disturbances

□ Skin Integrity □Lymphatic Problems