Nirvana Sports Medicine and Rehabilitation Services

Patient History Form

Name:_____**Contact Phone:**_____**Date:**_____

Emergency Contact:_____**Emergency Contact Phone:**_____

Email Address:_____**Date of Birth:**_____

Height:_____**Weight:**_____**Date of Illness/Injury:**_____

Your Pain Level (0-10): **Current**:_____**Best:**_____**Worst**:_____

What makes the pain better:_____

Location of Pain:_____

Have you fallen or lost your balance in the last year: **Yes** **No**

If yes, how many times?_____ **Have you injured yourself as result?** **Yes** **No**

Are you afraid of falling? **Yes** **No** **Do you experience dizziness or vertigo? Yes** **No**

Medical History Do you have/had any of the following medical conditions?

	YES	NO		YES	NO
Heart Problems	___	___	Diabetes	___	___
High Blood Pressure	___	___	Active Tuberculosis	___	___
Pacemaker	___	___	Seizures	___	___
Urinary Incontinence	___	___	Cancer	___	___
Osteoporosis	___	___	Pregnant	___	___

Other Health Issues:_____

List any Allergies you may have:_____

Please list the medications you currently take, include any over the counter medications:

Medication	Prescription (Yes/No)	Dose	Frequency

List any other surgeries, injuries, or major medical problems within the last 5 years:

_____

_____

_____

Describe your current physical compliant and how it happened and when:

_____

_____

_____

Have you had ANY previous therapy for this problem: **Yes** **No** **Was it helpful**: **Yes** **No**

What type of therapy did you have:_____

Work/Employment Information:

What is your occupation: _____

Employer: _____

Describe your physical requirements of your job (how much you lift/carry, positions, time spent standing/sitting/walking:_____

_____

_____

_____

What is your Present Work Status:

___Working Full Time/Regular Duty
___Working Full Time/Modified Duty
___Not Working because of current injury
___Homemaker
___Retired
___Working Part Time/Regular Duty
___Working Part Time/Modified Duty
___Not Working for other reason
___Student
___Unemployed

Do you need assistance in communicating with your employer: **Yes** **No**

Social Information:

Do you use an Assistive Device: (Please check all that apply)

___Cane
___Walker, Rolling Walker or similar
___Wheelchair
___Motorized wheelchair
___Other_____

With who/whom do you live: (Please check all that apply)

___Alone
___Spouse/Significant Other
___Child or children
___Other relative(s)
___Group setting
___Personal care attendant/assistant
___Other_____

What goals would you like to achieve in therapy:

_____
_____
_____

What activities have you had functional limitations in performing due to this injury:

_____
_____
_____

I have completed this history form and know it to be accurate to the best of my knowledge and ability:

_____

Patient Signature