ACTIVE NW
PHYSICAL THERAPY & WELLNESS

301 N 3rd St
Coeur d'Alene, ID 83814
Phone 208-215-2210
FAX 208-215-2209
www.activenwpt.com

MEDICAL HISTORY

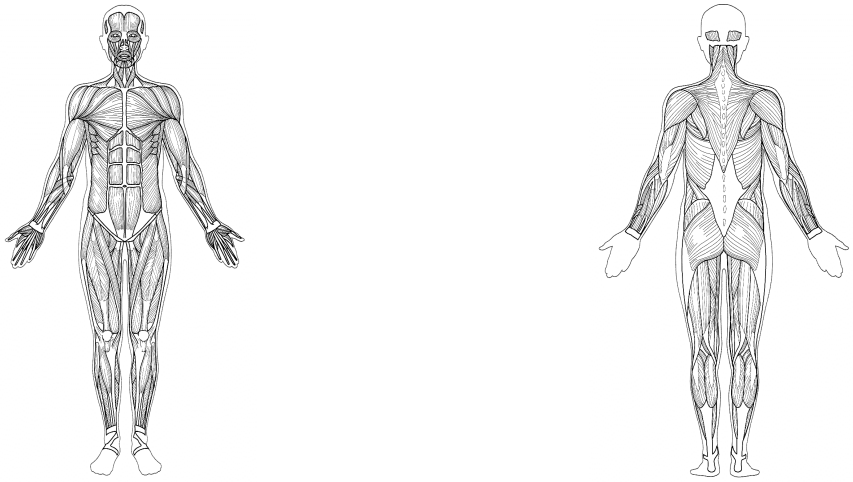
Name: _____ Age: _____Today's Date: _____

Please indicate your pain level on the days below based on a scale of 0 to 10 with 0 being no pain and 10 being the worst pain imaginable: Today _____ Best Day _____ Worst Day _____

Please list your chief complaints and indicate on the body diagram where you are having symptoms.

_____

_____



CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ActiveNW Physical Therapy & Wellness to furnish medical care and treatment to (patient name) _____ considered necessary and proper in diagnosing and treating his/her physical condition.

Patient / Guardian Signature: _____ Date: _____

Date of last complete Physical Exam_____ Health Care Provider _____

Medications: List all prescriptions and non-prescription medications including doses: _____

_____

Prednisone in the last year Y N Coumadin or other blood thinner Y N Chemotherapy Y N

Allergies: medications, food, exercise, others _____

Surgeries: (all surgeries earliest to most recent)_____

_____

ACTIVE NW
PHYSICAL THERAPY & WELLNESS

301 N 3rd St
Coeur d'Alene, ID 83814
Phone 208-215-2210
FAX 208-215-2209
www.activenwpt.com

Imaging, X-rays, MRI, CT: _____

_____

Exercise when injury free: _____

Infection: Hx of TB, bone, heart valve, kidney, chronic lung, abscesses, skin, hepatitis B,C, HIV/AIDS, Lymes, other _____

Circle if recent: fever, chills, night sweats, rash _____

Lung: Hx of Asthma (normal peak flow _____), chronic Bronchitis, TB, Pneumothorax, Lung diseases, hoarseness, pain worse with a deep breath, other _____

Heart: Hx of heart attack, angina, valve disorder, arrhythmia, heart block, cardiac arrest, implantable defibrillator, pacemaker, Congestive Heart Failure, cardiac hypertrophy, myocarditis, heart transplant, bypass surgery, high blood pressure. *Circle if resent symptoms of:* chest, arm, jaw pain with exercise, palpitations, fainting, other _____

Blood Vessels: Deep Vein Thrombosis, Arteriosclerosis of leg vessels, artery bypass surgery. *Circle if recent symptoms:* calf pain with walking, enlargement of calf or thigh, cold legs, leg or calf pain at rest, chest pain, other _____

Gastrointestinal: Ulcer, GERD, Irritable Bowel, Gall bladder stones, infection, Colitis, Crohns. *Circle if recent symptoms:* nausea, vomiting, gas, bloating, belly pain, diarrhea, bloody stool, change in stools, swallowing difficulties, other _____

Kidney: Kidney infection, Kidney stone. *Circle if recent symptoms:* pain with urination, facial swelling, no urination for 24 hrs, loss of urine control, decrease in urination, other _____

Hormonal: Thyroid or Adrenal condition, osteoporosis, early menopause, eating disorder, Diabetes.

Rheumatologic: Rheumatoid Arthritis, Fibromyalgia, Lupus, Scleroderma, Psoriatic Arthritis, Ankylosing Spondylitis, other _____

Spine/Orthopedic/Bones: fracture, dislocation, neck/back problem, motor vehicle accident, ankle sprains

_____

Mental: Depression, panic attack, generalized anxiety, psychotic disorder, borderline disorder, suicide attempt, decline in memory and cognitive function, other _____

Cancer/Blood: Anemia, bleeding disorder, list cancers and dates: _____

Sleep Dysfunction: restless legs, insomnia, # of hours sleep per night. _____

What do you eat on an average day: _____