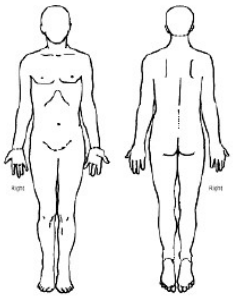
VITALITY
PHYSICAL THERAPY & WELLNESS

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Onset date of current condition: _____ Surgery Date: _____

How many times have you fallen in the last year? _____ Were you injured when you fell? _____

PAIN/SYMPTOMS	Indicate the location of your symptoms:
On a scale of **0 to 10**, indicate the intensity of your pain/symptoms: At best _____ At worst _____ Currently _____ **0 = No pain/symptoms** **10 = Pain that requires Emergency attention**	

SYMPTOM BEHAVIOR
Symptoms are better when _____
Symptoms are worse when _____
My goals for recovery are _____

PAST MEDICAL HISTORY			
High Blood Pressure ☐	Stroke/CVA ☐	Osteoporosis ☐	Heart/Circulation Problems ☐
Diabetes ☐	Irregular Thyroid ☐	Arthritis ☐	Bowel/Bladder Problems ☐
Cancer ☐	Asthma ☐	Lung Problems ☐	Neuromuscular Condition ☐
Specify/Indicate Other Conditions: _____			
Allergies: _____			
Surgeries: _____			

Previous treatment for this condition (including Home Health Care)? _____

Current Height:_____ Current Weight:_____

Patient Signature _____ Date: _____