Texas Health Huguley Hospital
Outpatient Therapy - Medical History Intake Form

Name:_____ Occupation: _____

Personal Medical History:
Has a doctor or health professional ever told you that you have or had any of the following conditions?
Please X all that apply and circle one that applies if multiple options:

Cardiac
__ Congenital heart defect
__ Heart problems /heart disease
__ High blood pressure
__ Low blood pressure
__ Circulation problems or blood clots
__ Pacemaker
__ Anemia
__ Chest pain/angina/palpitations

Lung Disease
__ Coughing/wheezing on exertion
__ Asthma
__ Emphysema
__ COPD
__ Tuberculosis

Joint/Muscle
__ Osteoporosis
__ Rheumatoid arthritis
__ Joint, tendon, or muscular pain
__ Osteoarthritis
__ Fibromyalgia

Gastrointestinal
__ Abdominal pain/bloating/gas
__ Painful bowels/loose stool/constipation
__ Ulcers
__ Irritable bowel syndrome
__ Chron's Disease
__ Colitis
__ Diverticulitis

Neurological
__ Epilepsy/seizure disorder
__ Stroke/CVA
__ Multiple sclerosis
__ Dizziness/vertigo/fainting/blackouts
__ Parkinson's

Psychological
__ Depression
__ Anxiety
__ Bipolar

General
__ Diabetes __ Severe Headaches __ High cholesterol __ Liver disease
__ Cancer __ Gout __ Prostate problems __ Kidney disease
__ Thyroid problems __ Skin problems __ Lyme disease __ Hepatitis A, B, C
__ Chemical dependency (alcoholism, etc.) __Other:_____

Any comments or additions to any of the above: _____
_____

Have you fallen in the last 6 months? YES NO Describe: _____
_____

Have you **recently** noted:
__ **Unexplained** weight loss/gain
__ Fatigue
__ Headaches
__ Difficulty swallowing
__ Nausea/vomiting
__ Dizziness
__ Fever/chills/sweats
__ Change in appetite
__ Numbness/tingling
__ Shortness of breath
__ Pain at night
__ Change of interest

Are you pregnant? __ Yes __ No How much do you smoke a day? _____
How many alcoholic beverages do you consume in a week?_____

Affix Patient ID Label Here

Surgical History:
Please list any surgeries or other conditions for which you have been hospitalized, within the last 10-15 years, including the approximate date and reason for the surgery or hospitalization:

Date	Reason for Surgery/ Hospitalization
1.	
2.	
3.	
4.	

Please describe any **significant injuries** for which you have been treated, in the last 10 years, (including fractures, dislocations, sprains) and the approximate date of injury:

Date	Injury	Date	Injury
1.		3.	
2.		4.	

Allergies:
Any medication (s) you are allergic to: _____
Any other allergies:_____
Adhesive tape allergy: _____

Medications:
Please list any **prescription and over-the-counter** medication (s) you are currently taking (including pills, injections, and /or skin patches):
1._____ 5. _____ 9._____
2._____ 6. _____ 10._____
3._____ 7. _____11._____
4. _____ _____ 8. _____ 12. _____

Have you undergone any **diagnostic testing** (X all that apply)
__ Nerve conduction velocity __ EMG __ Bone Scan __ MRI
__ Cardiac stress test __ CT scan __ Blood test __ Urinalysis
__ Doppler studies __ X-rays Other:_____
Where was the test: _____
What were the results: _____
_____

Please mark (X) on any of the following **whose care you are under**
__ Medical Doctor (MD) __ Psychiatrist/Psychologist __ Rheumatologist
__ Pain Specialist __ Neurologist __ Chiropractor
Other: _____

Affix Patient ID Label Here

Pain of Current Injury

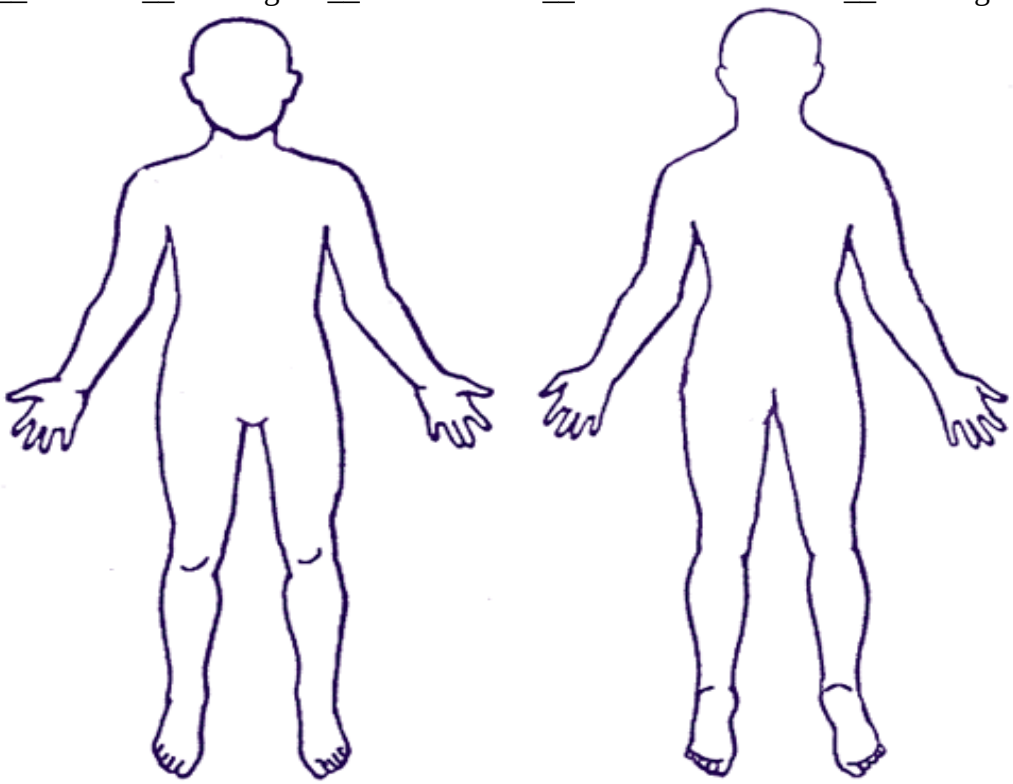
Onset due to: __ Sports __ Recreational __Trauma __Work related __ Injury at home __Unknown
__ Sudden __ Slow onset __ Chronic (more than 2 months)
Other: _____

Describe your symptoms trend: __Improving __Unchanging __Worsening

Frequency of your pain: __Constant __Intermittent (daily) __Occasional (less than daily)
__ Sporadic (less than weekly) More specifically _____

Pain Intensity
0 = No pain, 10 = pain so intense you need to go to the hospital, worst imaginable
At worst(highest it gets): _____ At best(lowest it gets): _____ Pain worse at: __ Morning __ Day __ Night
At rest: _____ With movement: _____ Is the pain worse with coughing or sneezing? YES NO
Specify movements: _____

Please indicate where your pain/symptoms are by marking X at the location and check how your pain feels:
__Ache __Burning __Numbness __ Pins and needles __Stabbing Other:_____



What is your **goal** for therapy? _____
_____
_____

Patient signature: _____ **Date:**_____

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