FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

HEALTH HISTORY

1. General Health History

Patient Name

What is your occupation?

How would you describe your general health?
Excellent Average Poor
Good Fair

Please rate your diet
Excellent Moderate Poor
Good Fair

Please list your typical

Breakfast

Lunch

Dinner

Fluid Intake

Do you engage in regular exercise?
None 3-4x a week
1-2x a week 5-7x a week

If yes, please list what type of exercise?

Do you use chewing tobacco? No Yes

Do you vape? No Yes

Do you smoke?
No Yes
If yes, how many cigarettes a week?

Do you drink alcoholic beverages?
No Yes
If yes, how many drinks a week?

Are you currently seeing a psychologist/counselor?
No Yes

What is your current level of stress?
High Moderate Low

2. Cardiopulomary History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Arrhythmias					**Asthma**				
Mitral valve prolapse					**COPD**				
Pacemaker					**Chronic bronchitis**				
Murmur					**Congestive heart failure**				
Heart attack					**Episodes of fainting/blacking out**				
Angina					**Aortic aneurysm**				
Hypertension					**Deep vein thrombosis (DVT)**				
Hypotension					**Raynaud's disease/phenomenon**				

If yes to personal history, please list the date of onset or if the problem is ongoing below:

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3. Neurologic History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Stroke					**Migraines**				
Multiple Sclerosis					**Unusual or frequent headaches**				
Polio					**Bell's Palsy**				
Aneurysm					**Shingles**				
Peripheral neuropathy					**Seizures**				
Concussion					**Parkinson's Disease**				
Head trauma					**Chronic pain conditions**				

If yes to personal history, please list the date of onset or if the problem is ongoing below:

4. Gastrointestinal History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Liver problems					**Stomach ulcers**				
Ulcerative colitis					**Hemorrhoids**				
Irritable bowel syndrome					**Gallstones**				
Esophageal reflux					**Constipation**				
Anorexia					**Bulemia**				

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5. Endocrinological History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Persona		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Diabetes					**Addison's Disease**				
Hypothyroidism					**Cushing's Syndrome**				
Hyperthyroidism					**Hormone Replacement Therapy**				

If yes to personal history, please list the date of onset or if the problem is ongoing below:

6. Pelvic Floor History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Urinary incontinence					**Endometriosis**				
Fecal incontinence					**C-section**				
Pelvic pain					**Sexually transmitted disease**				
Hysterectomy					**Sexual dysfunction**				

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7. Musculoskeletal History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Osteoporosis/Osteopenia					**Hip dysplasia**				
Surgeries					**Scoliosis**				
Fibromyaglia					**Flat feet**				
Hernia					**High arches**				
Rheumatoid Arthritis					**Osteoarthritis**				
Fractures/Joint Trauma					**Ankylosing Spondylitis**				

If yes to personal history, please list the date of onset or if the problem is ongoing below:

8. Psychological/Emotional History

Have you, or any immediate family member, ever been diagnosed with:

	Personal		Family			Personal		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Depression					**ADHD**				
Anxiety					**Physical Abuse**				
Bi-polar disorder					**Verbal Abuse**				

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9. Current Medications

Prescription medication—please list, or attach a copy below:

Name & Dose	Reason	Date/Year Started

Over the counter medications, vitamins, or supplements—please list, or attach a copy below:

Name & Dose	Reason	Date/Year Started

10. Surgical and Hospitalization History

Please list all surgeries and/or overnight hospital stays and reasons why below:

Type of Surgery	Reason	Date