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

HEALTH HISTORY

1. General Health	His	tory							
Patient Name					Do you engage in regular e None 3-4x a 1-2x a week 5-7x a	week			
What is your occupation?					If yes, please list what type	of exe	ercise?	1	
How would you describe your general health? Excellent Average Poor Good Fair				□ No □ Yes					
Please rate your diet Excellent Modera Good Fair	ate [Poo	r		Do you smoke? ☐ No ☐ Yes If yes, how many cigarettes	a we	ek?		
Please list your typical					Do you drink alcoholic bev	erag	es?		
Breakfast					☐ No ☐ Yes If yes, how many drinks a w	eek?			
Lunch					Are you currently seeing a p	osycho	ologist	t/coun	selor
Dinner					What is your current level High Moderate		ress?		
Fluid Intake						2011			
2. Cardiopulomar Have you, or any immediate	e fami		nber,	ever b	een diagnosed with:	Pers	onal	Fan	nily
	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 Deep vein thrombosis (DVT)				
Hypertension Hypotension					Raynaud's disease/phenomenon				
	lease	list the	e date	of on	set or if the problem is ongoing belo	ow:			

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3. Neurologic History

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

	Pers	onal	Far	nily		Pers	onal	Fan	nily
	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				

yes to personal mistory,	piease	1131 (11)	e date	01 011	set or if the problem is ongoing be	IOW.			
4. Gastrointestina	al His	stor	y						
			_		1 21				
lave you, or any immedia	te ramii	y mer	nber,	ever b	een diagnosed with:				
	Pers	onal	Far	nily		Pers	onal	Far	nily
	Yes	No	Yes	No		Yes	No	Yes	No
Liver problems					Stomach ulcers				
Ulcerative colitis					Hemorrhoids				
Irritable bowel syndrome					Gallstones				
Esophageal reflux					Constipation				
Anorexia					Bulemia				
f ves to personal history	nleace	lict th	e date	of on	set or if the problem is ongoing be	low:			
Tyes to personal history,	picase	וואר נוו	e date	01 011	iset of it the problem is ongoing be	iow.			



5. Endocrinological History

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

	Pers	onal	Fan	nily		Pers	ona	Fan	nily
	Yes	No	Yes	No		Yes	No	Yes	No
Diabetes					Addison's Disease				
Hypothyroidism					Cushing's Syndrome				
Hyperthyroidism					Hormone Replacement Therapy				

					Hormone Replacement Therapy				
f yes to personal history	y , please	list the	e date	of on	set or if the problem is ongoing	below:			
70000 0000000000000000000000000000000	, p								
6. Pelvic Floor H	listory								
lave you, or any immed	liate fami	ly mei	mber,	ever t	peen diagnosed with:				
	Down	sonal	Far	nily		Dore	onal	Far	mily
	Yes	No	Yes	No		Yes	No	Yes	N
· · · · · · · · · · · · · · · · · · ·					Endometriosis			Yes	N
Fecal incontinence					C-section			Yes	Ne
Urinary incontinence Fecal incontinence Pelvic pain					C-section Sexually transmitted disease			Yes	N
Fecal incontinence					C-section			Yes	N
Fecal incontinence Pelvic pain					C-section Sexually transmitted disease			Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease	Yes		Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	N
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No
Fecal incontinence Pelvic pain Hysterectomy	Yes	No	Yes	No	C-section Sexually transmitted disease Sexual dysfunction	Yes		Yes	No

7. Musculoskeletal History

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

	Pers	onal	Fan	nily		Pers	onal	Fan	nily
	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, p	lease	list th	e date	of on	set or if the problem is ongoing be	low:			
8. Psychological/E	mo	tion	al H	isto	ry				
Have you, or any immediate									
mave you, or any immediate					cen diagnosed with.				
	Yes	onal No	Far Yes	nily No		Pers		Fan	
Danasalan	res	NO	res	INO	ADUD	Yes	No	Yes	No
Depression Anxiety					ADHD Physical Abuse				
Bi-polar disorder					Verbal Abuse				
Di polai disordei					Versui Abuse				
If yes to nersonal history in		10		•					
ii yes to personal instoly, p	ilease	list th	e date	e of on	set or if the problem is ongoing be	low:			
π yes to personal instory, ρ	nease	list th	e date	of on	set or if the problem is ongoing be	low:			
yes to personal history, p	nease	list th	e date	of on	set or if the problem is ongoing be	low:			
yes to personal history, p	nease	list th	e date	of on	set or if the problem is ongoing be	low:			
yes to personal history, p	nease	list th	e date	e of on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	e of on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	of on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	of on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	e or on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	e or on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	or on	set or if the problem is ongoing be	low:			
yes to personal mistory, p	nease	list th	e date	e or on	set or if the problem is ongoing be	low:			



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