MCMC
MID-COLUMBIA MEDICAL CENTER
OUTPATIENT THERAPY SERVICES
Water's Edge
541-296-7202

HEALTH HISTORY FORM

Name: _____ Date of birth: ____/____/_____

Occupation:_____ Referred By:_____

Reason for today's visit: _____

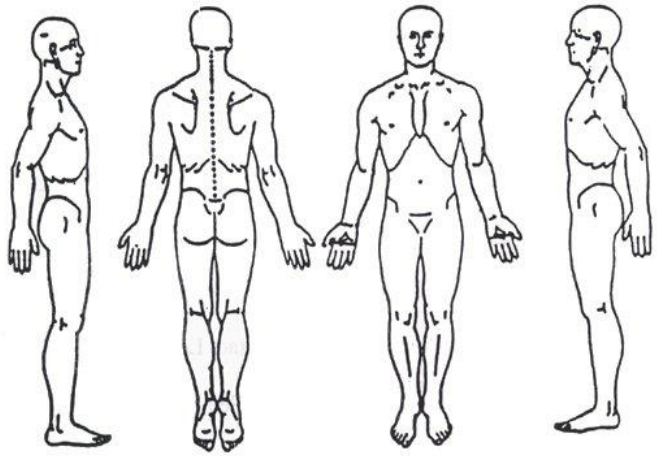
_____

What are your goals for physical therapy? _____

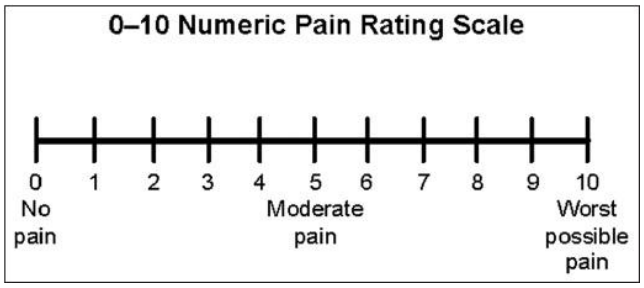
_____

When did your symptoms begin? Date_____/____/_____

Location of symptoms: _____
(Please describe and/or mark on body diagram below)



(Please Circle Current Pain Level)



Are you currently having or have you experienced any of these symptoms in the past 3 months?

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Shortness of Breath
- ☐ Pins/Needles
- ☐ Numbness
- ☐ Skin Rash
- ☐ Headaches
- ☐ Vision Problems
- ☐ Hearing Loss
- ☐ Bowel/Bladder Problems
- ☐ Chest Pain

Name: _____ Date of birth: ____/____/_____

Please Check all conditions that apply present or past:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Blood Clots
- ☐ Lymphedema
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Asthma
- ☐ COPD
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Gout
- ☐ Kidney Problems
- ☐ Dizziness/Fainting
- ☐ Depression
- ☐ Anxiety
- ☐ Emotional/Psychological Problems
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ TMJ/Jaw pain
- ☐ Bladder Problems
- ☐ Bowel Problems
- ☐ Chemical Dependency (alcohol/drugs)
- ☐ Smoking
- ☐ Pregnant or Attempting Pregnancy

Other Illnesses/Injuries/Health Conditions or Surgeries: _____

_____

_____

Please list all medications you are currently taking: _____

_____

_____

Allergies: _____

_____

X-Rays, Imaging, other Tests related to your condition: _____

How many days per week do you exercise at least 30 minutes: □ 0 □ 1-2 □ 3-5 □ 5-7

- ☐ Walking
- ☐ Running
- ☐ Biking
- ☐ Swimming
- ☐ Weight Lifting
- ☐ Organized Sports
- ☐ Other:_____
  _____
  _____

Please Rate Your General Health: □ Good □ Fair □ Poor