Choice Therapy – Hibbing
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Choice Therapy

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CONFIDENTIAL HEALTH HISTORY

Name: ____ **Date:**____________________

Primary Care Physician: ___________________________________

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Occupation: ____

Height: _________ Weight: ___________

Reason for therapy appointment: ____

Date of onset: _________________ **Description of onset**: ____________________________________

Other types of treatment for this condition (please circle):

Home Care Massage Chiropractor Specialist Other:______________________

Have you lost any days of work? YES/NO If yes, explain? _____________________________________

Rate Pain Level (0) is no pain, (10) is worst possible pain

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Best pain in last week	0	1	2	3	4	5	6	7	8	9	10
Worst pain has been in last week	0	1	2	3	4	5	6	7	8	9	10

What makes your pain better?

____

What makes your pain worse?

____

List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms: ____ (ex. Stairs, reaching overhead)

Over the last month my condition is: ☐ Getting better ☐ Getting Worse ☐ Staying the same ☐ Unstable

Any prior injuries? Yes No If yes, explain:

____

Please list current medications ____

____

Are you currently taking blood thinning or anticoagulant medications for any medical condition? YES/NO

ALLERGIES: ____

Are you latex sensitive? YES/NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ____________________ 2. ____________________ 3. ____________________

I live at my own house (please check all that apply):

- ☐ Independently
- ☐ With strong local support
- ☐ With limited/no local support
- ☐ I am a caregiver
- ☐ I am not living in my own house

Do you have an Advanced Directive stating "Do not resuscitate"? YES/NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES/NO

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Changes in appetite
- ☐ Changes in bowel or bladder function
- ☐ Dizziness/light headedness
- ☐ Difficulty swallowing
- ☐ Difficulty maintaining balance while walking
- ☐ Falls
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Weakness/fatigue
- ☐ Weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Anemia
- ☐ Alzheimer's
- ☐ Asthma
- ☐ Cancer (type) ____________________
- ☐ Chemical dependency/alcoholism
- ☐ Concussion
- ☐ Dementia
- ☐ Depression
- ☐ **NONE**
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney/liver problems
- ☐ Lung problems
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker inserted
- ☐ Parkinson's disease
- ☐ Rheumatoid arthritis
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Traumatic Brain Injury
- ☐ Other ____________________

Patient Name (printed): ____

Patient Signature: ______________________________ **Date:** ____________________