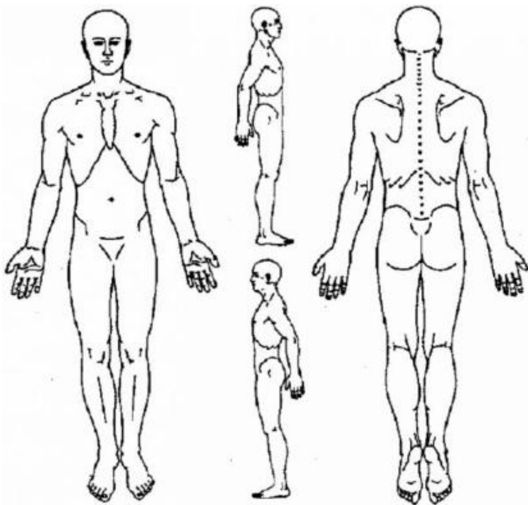
ALPINE

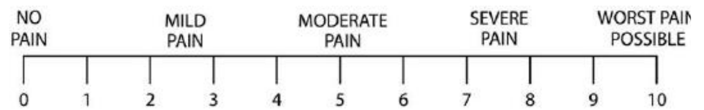
HEALTH HISTORY

NAME: AGE:

Reason for today's visit:
Date of onset of symptoms ________________ Onset was *(check one)* ☐ Sudden ☐ Gradual ☐ N/A
Are your symptoms the result of an accident? ☐ No ☐ Yes Motor Vehicle_____ Work _______
Since onset, are your symptoms getting ☐ Better ☐ Worse ☐ No Change
Nature of symptoms *(check all that apply)* ☐ Sharp ☐ Dull ☐ Aching ☐ Tingling ☐ Throbbing ☐ Numbness ☐ Occasional ☐ Random ☐ Constant ☐ Other ________________________________
As the day progresses, do your symptoms ☐ Increase ☐ Decrease ☐ Stay the same
Does this pain wake you at night? ☐ No ☐ Yes How many times? _________
Normal hours of sleep: _____ hours Current hours of sleep: _____ hours
Are your symptoms worse in the morning, evening or neither? ☐ Morning ☐ Evening ☐ Neither
What aggravates symptoms?
What relieves symptoms?

Mark an X on the body chart below where you are experiencing areas of pain or abnormal sensation:





Please rate your level of pain below, using 0-10 scale:

At worst: _____ Current: _____ At best: _____

Have you had treatment for your current symptoms? *(check all that apply)* ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Bracing/Taping ☐ Traction ☐ Injection ☐ Biofeedback ☐ TENS unit ☐ Counseling ☐ Medication ☐ Other__________________
Have you had any of the following tests for your current symptoms? ☐ X-ray ☐ MRI ☐ CT Scan ☐ Arthrogram ☐ Other ☐ None Findings/Results: ____
Have you had surgery for the present condition? ☐ No ☐ Yes If yes, list surgery type and date: ____

(*questions continue on second page*)

CURRENT SYMPTOMS *(check all that apply)* ☐ NONE

☐ Balance problems	☐ Bowel/Bladder changes	☐ Chest Pains/Pressure at rest
☐ Difficulty sleeping	☐ Difficulty Swallowing	☐ Dizziness or fainting
☐ Fever/chills	☐ Frequent falls	☐ Generalized weakness/fatigue
☐ Night pain/sweats	☐ Numbness in limbs	☐ Pregnancy
☐ Severe headaches	☐ Shortness of breath	☐ Stomach pain or Ulcer
☐ Swollen ankles or legs	☐ Unexplained weight changes	☐ Vision/Hearing Problems
☐ Joint pain/dislocation	☐ Other ____	

MEDICAL HISTORY: *please indicate if you have (or had) any of the following conditions:* ☐ NONE

☐ Anxiety/Depression	☐ Arthritis _____________	☐ Cancer ____________________________
☐ Circulatory problems	☐ Diabetes	☐ Epilepsy/Seizures/Convulsions
☐ Head trauma/Concussion	☐ Heart Problems/Disease	☐ Hernia
☐ High Blood Pressure	☐ Immune Deficiency Disease	☐ Infectious Disease ___________________
☐ Peripheral Neuropathy	☐ Liver Problems/Disease	☐ Lung Disease/Breathing Difficulties
☐ Multiple Sclerosis	☐ Osteoporosis	☐ Pacemaker
☐ Stroke	☐ Parkinson's Disease	☐ Other_________________

HABITS & ACTIVITIES

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Do you smoke/vape? ☐ NO ☐ YES For how long? How much?
Do you drink alcohol? ☐ NO ☐ YES Number of drinks per week?
Amount of coffee/caffeinated drinks per day, in ounces? (1 cup coffee = 8 oz, 1 can soda = 12 oz)
Stress Level? ☐ None ☐ Mild ☐ Moderate ☐ High ☐ Extreme Reason(s):
Employment Status: ☐ Full time ☐ Part time ☐ Restricted Duty ☐ Retired
Occupation/Type of work:
Do you exercise? ☐ NO ☐ YES Frequency? Type:

MEDICATIONS: *(please include prescription, OTC, herbals, vitamins, supplements, etc – or provide existing list)*

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Is there other information regarding your medical history that we should know about? __________________________

____

What is your goal for therapy at this time? ____

____

I have stated all my known medical conditions, answered all questions honestly, and agree to keep the therapist updated with changes. I will not hold my therapist or any staff member responsible for any errors or omissions I may have made in the completion of this form.

Signature of Patient (or Guardian): ____ Date: __________________

(Please refrain from wearing perfumes, colognes and scented lotions for therapy sessions. Due to allergies and enclosed, small spaces, even the mildest scents can become overwhelming to the sensitivities of others.)