GORDONPT Physical Therapy

70 Main Street, Suite 201
North Andover, MA 01845
978-315-2500 (p)
978-315-2501 (f)

# Health Status Form

Date: | Patient Name:

Present Complaint: | Date of Onset:

How did injury occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other _____

Do you have pain? ☐ Yes ☐ No | Rate Pain (0 no Pain – 10 high pain) At Best: _____ At Worst: _____

Have you had physical therapy for this problem before? ☐ Yes ☐ No | If yes, when:

What tests have been done for this condition? (check all that apply)

☐ CT Scan ☐ MRI ☐ X Ray ☐ EMG ☐ Bone Scan ☐ Ultrasound ☐ None ☐ Other _____

Describe your overall general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

## Past Medical History

*If yes, please provide details*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High Cholesterol | ☐ Yes | ☐ No | _____ | Stroke | ☐ Yes | ☐ No | _____ |
| High Blood Pressure | ☐ Yes | ☐ No | _____ | Blood Clots | ☐ Yes | ☐ No | _____ |
| Heart Problems | ☐ Yes | ☐ No | _____ | Pacemaker | ☐ Yes | ☐ No | _____ |
| Seizures/Neurological | ☐ Yes | ☐ No | _____ | Cancer/Tumor | ☐ Yes | ☐ No | _____ |
| Behavioral/Learning | ☐ Yes | ☐ No | _____ | Diabetes | ☐ Yes | ☐ No | _____ |
| Anxiety/Depression | ☐ Yes | ☐ No | _____ | Hepatitis/HIV | ☐ Yes | ☐ No | _____ |
| Genetic/Congenital | ☐ Yes | ☐ No | _____ | Asthma/COPD | ☐ Yes | ☐ No | _____ |
| Are you pregnant? | ☐ Yes | ☐ No | _____ | Do You Smoke? | ☐ Yes | ☐ No | _____ |
| Bone Joint Problems | ☐ Yes | ☐ No | _____ | | | | |

Other (describe): _____

Significant Past Surgeries: _____

## Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: _____

_____

_____

List all food and medical allergies (include latex & adhesives): _____

_____

_____

## Daily Activities

What does your job and/or home duties require? Check all that apply:

| | | | |
|---|---|---|---|
| ☐ Computer Work | ☐ Standing | ☐ Reaching | ☐ Carrying |
| ☐ Kneeling/Squatting | ☐ Walking | ☐ Climbing | ☐ Lifting |
| ☐ Repetitive Movement/Twisting | ☐ Writing | ☐ Pushing/Pulling | ☐ Other _____ |

_____ _____

Signature of Patient or Legally Authorized Representative | Date