ORENSTEIN
PHYSICAL THERAPY

Health History

Date: _____

Name: _____ Date of Birth: _____Height_____Weight:_____

Referral: _____Handedness: Right / Left

Primary care physician: _____

Do you have access to a health club or swimming pool? _____

Occupation: _____

Are you currently being treated for, or have you in the past been treated for any of the following:

Arthritis local/systemic	Yes	No	Cancer	Yes	No
Chemical/alcohol dependency	Yes	No	Diabetes	Yes	No
GI/digestive disturbances	Yes	No	Heart Disease	Yes	No
Infectious disease	Yes	No			
Psychological/mood disorder	Yes	No			

If yes to any of the above, please explain: _____

_____

Please indicate all major surgeries – type and date of surgery. List most recent, first:

_____

_____

Please list current medications: _____

_____

Are you using vitamins or supplements? Would you like to learn more? _____

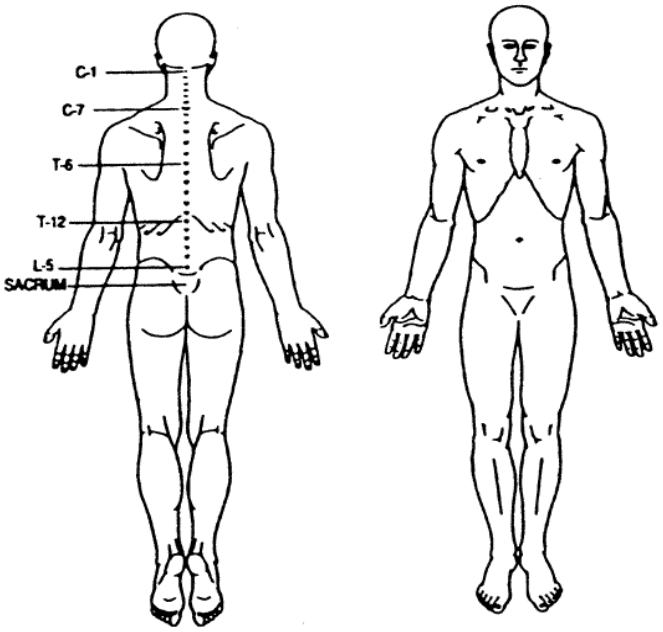
What brings you to see us? _____

Have you had this before? _____ Was it treated? _____

If so, how? _____

What would you like to achieve? _____

Use the diagram below to highlight areas of concern.



What is the nature and location of your primary concern?_____.

What makes it worse? _____.

What makes it better? _____.

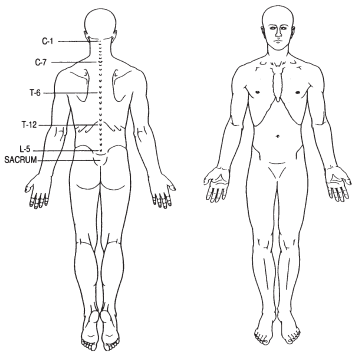
Is it constant or intermittent? _____.

Do you feel different from morning to evening? _____.

Has the above concern been evaluated by a physician? _____.

If yes, were there tests taken? _____.

DO NOT WRITE IN THE SPACE BELOW.



Posture/gait:

Range of motion:

Strength:

Neuromuscular testing

SLR

Dural sleeve

Strength, sensory, and reflex

Special screening tests:

Manual screening and myofascial patterns:

Today's trx/exercises:

Summary of findings

1.

2.

3.

4.

Impression:

Plan of Care:

Goals to achieve:

_____P.T.