Chester Community Physical Therapy Clinic
Widener University

Health History Form

First Name:_____ **Last Name:** _____ **Date:** _____

What is the reason for your visit today? _____

Briefly describe how your problem began: _____

When did your problem begin? _____

What is your biggest goal for therapy? _____

How would you rate your current health? EXCELLENT VERY GOOD GOOD FAIR POOR

Please circle yes or no of you have or have had any of the following conditions:

Smoke / chew tobacco -packs / day: _____	**Y / N**	Diabetes	**Y / N**	Lupus	**Y / N**
Use of illegal substances	**Y / N**	Heart Attack	**Y / N**	Fibromyalgia	**Y / N**
Drink alcoholic beverages - amt / day: _____	**Y / N**	Cardiac Bypass	**Y / N**	Osteoarthritis	**Y / N**
High Blood Pressure	**Y / N**	Pacemaker	**Y / N**	Rheumatoid Arthritis	**Y / N**
High Cholesterol	**Y / N**	Angina / Chest Pain	**Y / N**	Osteoporosis or Osteopenia	**Y / N**
Bowel / Bladder Dysfunction	**Y / N**	Hepatitis	**Y / N**	Scoliosis	**Y / N**
Acid Reflux or Ulcers	**Y / N**	Emphysema	**Y / N**	Sexually Transmitted Disease	**Y / N**
Thyroid Disorder	**Y / N**	COPD	**Y / N**	Multiple Sclerosis	**Y / N**
Bleeding Disorder	**Y / N**	Asthma	**Y / N**	Cancer (site: _____)	**Y / N**
Seizures / Epilepsy	**Y / N**	Kidney Disease	**Y / N**	Recent Infection	**Y / N**
Lyme Disease	**Y / N**	Stroke	**Y / N**	Headaches or Migraines	**Y / N**
Pregnant (# weeks_____)	**Y / N**	Congestive Heart Failure	**Y / N**	Dizziness or Fainting	**Y / N**
Chronic Pain	**Y / N**	Anxiety	**Y / N**	Depression	**Y / N**

Additional Details:

_____

Please list all medications / supplements you currently take.

_____

_____

List all allergies you may have: _____

List all previous surgeries and / or injuries and dates:

_____

_____

To the best of my ability, I have given and included all pertinent medical information.

Client / Guardian Signature: _____ **Date:** _____

Health History reviewed by physical / occupational therapy student and used in determining plan of care.
Student Therapist Signature: _____ **Date:** _____

Licensed Therapist Signature: _____ **Date:** _____