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Please print clearly so we may transfer your information to our medical database for proper claim submission.
The privacy and security of your personal health information is very important to us.
We will do our best to answer your questions in a professional and private manner.
Thank you for trusting us with your health care.

PATIENT INFORMATION

Last Name: First: MI: Nickname:

Address: City: State: ZIP:

Sex: Male Female Status: Minor Single Married Divorced Widowed

Date of Birth: SS#:

Employer: Occupation:

Address: City: State: ZIP:

Work Related Injury?: Auto Related Injury?: Date of Injury:

How did you hear about Naperville Physical Therapy? Physician Insurance Friend/Relative Other

Whom may we thank for referring you?

In case of emergency, who should be notified? Name: Relationship: Phone:

PREVIOUS ADDRESS IF LESS THAN TWO YEARS AT PRESENT ADDRESS

Address: City: State: ZIP:

INSURANCE – Who is responsible for this account? Please have your insurance card available for us to make a copy.

Insured Name: Relationship to Patient:

Address: City: State: ZIP:

Date of Birth: SS#:



Patient Health History Form

Name: _____ Date: ____/____/____

Age: _____ Height: _____ Weight: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Are you on a work restriction from your Physician? Yes No Do you smoke? Yes No

Do you have a pacemaker? Yes No Are you latex sensitive? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to: _____

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

Fatigue	Numbness or tingling	Constipation
Fever/chills/sweats	Muscle weakness	Diarrhea
Nausea/vomiting	Dizziness/lightheadedness	Shortness of breath
Weight loss/gain	Heartburn/indigestion	Fainting
Difficulty maintaining balance while walking	Changes in bowel or bladder function	Cough
Falls	Difficulty swallowing	Headaches

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

Cancer	Depression	Thyroid Problems
Heart problems	Lung problems	Diabetes
Chest pain/angina	Tuberculosis	Osteoporosis
High blood pressure	Asthma	Multiple Sclerosis
Circulation problems	Rheumatoid arthritis	Epilepsy
Blood clots	Other arthritic condition	Kidney problems
Stroke	Bladder/urinary tract infection	Ulcers
Anemia	Eye irritation/infection	Liver problems
Chemical dependency (i.e. alcoholism)	Sexually transmitted disease/HIV	Hepatitis

Has anyone in your immediate family (parents, brothers, sisters) **EVER** been diagnosed with any of the following conditions (check all that apply):

Cancer	Diabetes	Tuberculosis
Heart problems	Stroke	Thyroid problems
High blood pressure	Depression	Blood clots

During the past month have you been feeling down, depressed or hopeless? Yes No
 During the past month have you been bothered by having little interest or pleasure in doing things? Yes No
 Is this something with which you would like help? Yes No
 Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No
 Have you ever taken steroid medications for any medical conditions? Yes No
 Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes No

Please list any medications you are currently taking (**INCLUDING** pills, injections and/or skin patches):

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

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

1.	2.	3.
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What date (roughly) did your present symptoms start?

Date: _____ / _____ / _____

What do you think caused your symptoms? _____

My symptoms are currently:

Getting better Getting worse Staying about the same

Treatment received for this problem (chiropractic, injections, etc): _____

Please list special tests performed for this problem (X-ray, MRI, labs): _____

Have you ever had this problem before:

Yes

No

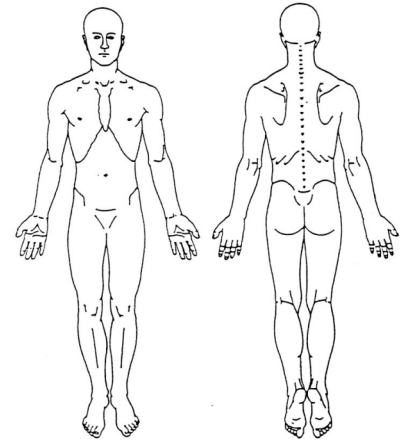
When: _____

Treatment rec'd: _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas on the chart at right with the following symbols to describe and pinpoint where you feel symptoms.



✓ Shooting/sharp pain

() Dull/aching pain

! Numbness

= Tingling

My symptoms currently:

Come & go

Are constant

Are constant, but change with activity

Aggravating Factors: Identify three important positions or activities that make your symptoms worse:

Easing Factors: Identify three important positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

No problem sleeping

Difficulty falling asleep

Awakened by pain

Sleep only with medication

When are your symptoms worst?

Morning

Afternoon

Evening

Night

After exercise

When are your symptoms the best?

Morning

Afternoon

Evening

Night

After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable", please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

What are your goals for physical therapy?