NAME	DATE OF BIRTH	PHONE
ADDRESS	EMAIL	
ORDERING DOCTOR	PRIMARY DOCTOR	
INSURANCE CO	POLICY HOLDER	

Please CIRCLE your answers:

1. Is this a new, recurring or chronic condition?

☐ NEW ☐ RECURRING ☐ CHRONIC

2. What type of injury or condition is this?

☐ PRE SURGICAL ☐ POST SURGICAL ☐ WORK COMP ☐ AUTO ☐ N/A

3. How long have you had this injury/condition?

☐ LESS THAN 1 MONTH ☐ 1 - 3 MONTHS ☐ MORE THAN 3 MONTHS

4. How many visits have you had with Physical or Occupational therapy this calendar year? _____

5. How many Chiropractic visits have you had this calendar year? _____

6. Do you moderately exercise 3 times per week? (when feeling well)	☐ YES	☐ NO
7. Do you feel confident that you will overcome this condition?	☐ YES	☐ NO
8. Are you presenting today because of a fall?	☐ YES	☐ NO
9. Have you experienced 2 or more falls within the last 12 months?	☐ YES	☐ NO
10. Do you have difficulty with your walking or balance?	☐ YES	☐ NO
11. Do you use any assistive walking devices? (cane, crutches, wheelchair, walker)	☐ YES	☐ NO

PATIENT NAME

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HERITAGE VALLEY HEALTH SYSTEM

HEALTH/MEDICAL HISTORY FORM

CHRONIC LUNG DISEASE	☐ YES	☐ NO	ANXIETY	☐ YES	☐ NO
CANCER If yes, Type _____	☐ YES	☐ NO	OBESITY	☐ YES	☐ NO
CARDIOVASCULAR DISEASE	☐ YES	☐ NO	TOBACCO USE	☐ YES	☐ NO
STROKE	☐ YES	☐ NO	ALCOHOL USE	☐ YES	☐ NO
NEUROLOGICAL CONDITION If yes, type _____	☐ YES	☐ NO	CHRONIC PAIN (greater than 3 months)	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO	PACEMAKER	☐ YES	☐ NO
DEPRESSION	☐ YES	☐ NO	DEFIBRILLATOR	☐ YES	☐ NO

SURGERIES and/or additional MEDICAL PROBLEMS (with approximate date)

MEDICATIONS (prescription and over the counter)

ALLERGIES (drugs, anesthesia, food, blood, soap, dyes, environment)

LATEX SENSITIVITY Have you experienced the following symptoms (abdominal cramps, itching or peeling skin, throat congestion, runny nose, red swollen eyes, swollen lips, difficulty breathing) after:

Handling rubber products such as elastic bandages, baby bottle nipples, erasers, rubber gloves, rubber grips on handle bars, rubber bands, shoes	☐ YES	☐ NO
Blowing up balloons	☐ YES	☐ NO
Eating bananas, avocados, tropical fruits (kiwi, papaya)	☐ YES	☐ NO

NUTRITIONAL SCREENING

Changes in body weight? Please circle: ☐ Gain ☐ Loss # LB amount _____	☐ YES	☐ NO
Diet restrictions Type of diet _____	☐ YES	☐ NO
Recent Appetite	☐ Good	☐ Poor

SOCIAL

Have you been abused physically, emotionally, or sexually? For assistance call Case Management at 724-773-4800	☐ YES	☐ NO

PATIENT or GUARDIAN (if applicable) SIGNATURE: _____ DATE & TIME _____

THERAPISTS SIGNATURE: _____ DATE & TIME _____

PATIENT NAME

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