Integrative Pelvic Health

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Health History Form

Name:_____DOB:_____

Do you presently, or have you ever suffered from any of the following (*check all that apply):*

Condition		**Explain**	**Condition**		**Explain**
Heart Disease/Surgery			Thyroid Problems		
High Blood Pressure			Falls the last 6 months? How many?		
Pacemaker			Depression/Anxiety		
Pain/tightness in chest			History of smoking? Are you smoking currently?		
Stroke			Osteoporosis		
Diabetes			Fibromyalgia		
Dizziness			Osteoarthritis and which joints affected?		
Shortness of Breath			Other you want me to know about:		

Cancer: Type/Location/Grade: _____ Surgery: Yes/No Date of Surgery:_____
Radiation Dates (first and last date) and How many: _____
Chemotherapy Dates (first and last date) and How many: _____

Surgical History:
Total Joint Replacements: _____
Abdominal/Pelvic surgeries: _____
Spine Surgeries: _____
Other: _____

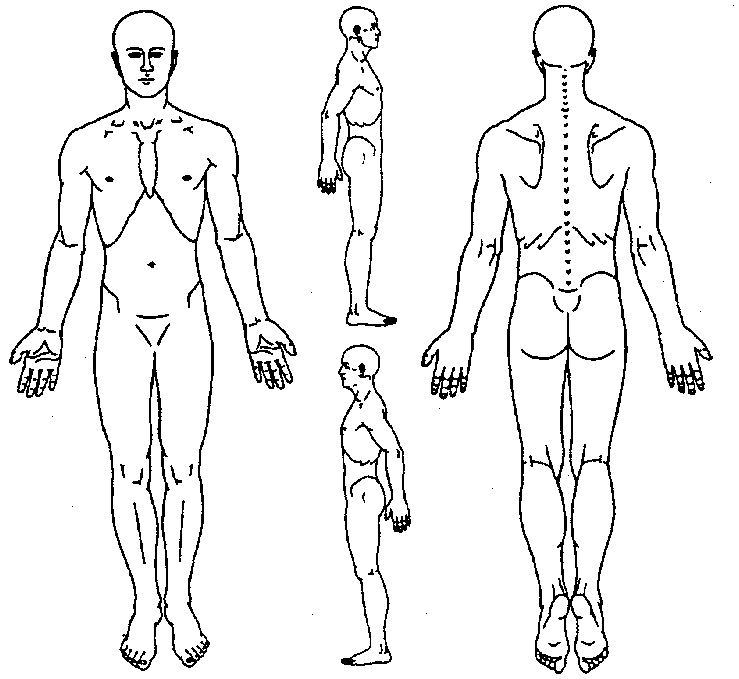
Areas of Pain: (*check all that apply):*

Low Back		Sciatic pain down Leg/Legs: L R Both		Feet	
Mid Back		Hips		Knees	
Neck		Tailbone: sacrum or coccyx		Abdomen/Belly	
TMJ		Wrists/Hands		Ribs	
Pubic Symphysis		Other:		Other:	

Is this injury related to: Work? Yes ____ No ____ Auto Accident? Yes ____ No ____ Other Accident? Yes____ No____
Date of Injury: _____ Is there an attorney involved? Yes_____ No_____

Pain Diagram:
On the diagrams below, mark where you are experiencing pain, right now. Use the letters below to indicate the type of pain and location of your sensations.
Key: A – ACHE B – BURNING N – NUMBNESS P – PINS & NEEDLES S – STABBING O – OTHER

In your areas of pain, what is the pain currently? _____
What has the pain been at worst in the past month? _____



Is this injury related to: Work? Yes ____ No ____ Auto Accident? Yes ____ No ____ Other Accident? Yes____ No____
Date of Injury: _____ Is there an attorney involved? Yes_____ No_____

List all the medications you are taking, including Prescription, Herbal and Over the Counter:

Name of Medication:	Reason taking it:	Name of Medication:	Reason taking it:
1.		5.	
2.		6.	
3.		7.	
4.		8.	

For Women Only:
Are you pregnant? Yes No If yes, what is your due date?_____ Are you on any restrictions? _____
Are you trying to get pregnant? _____ Number of pregnancies? _____ Number of live births? _____
Month and Year of live births_____
Miscarriages? _____ Abortions? _____ Cesarean Sections? _____
Birth weight of largest baby? _____ History of tearing with births? _____ What grade tear? _____
Episiotomies? Yes No How many_____ Forceps or vacuum assist with birth? _____
Did you experience post-partum depression? _____ Any other complications? _____
I consent that everything in this form is true and has been filled out to the best of my knowledge. It is my responsibility to let my physical therapist know of any changes to my health history.
Signed: _____ Date: _____