Adult Health History/Summary List

1. What is the reason for your visit? ________________________________

2. What would you like to accomplish by coming to therapy? ________________________________

3. Start of problem: _____/_____/____ Explain what happened: ________________________________

4. Have you ever had treatment for this problem before? ________________________________

5. Is English your primary language? ❏ No ❏ Yes If no, what is? ________________________________

6. Do you have any religious, spiritual or cultural needs that will apply to your care? ❏ No ❏ Yes
   If yes, please describe: ________________________________

7. Are you employed? ❏ No ❏ Yes If yes, what job? ________________________________

8. Do you smoke now or in the past? ❏ No ❏ Yes Number of years: ___________ Packs per day: ___________
   Date stopped ________________________________

9. Do you drink beer, wine or alcohol? ❏ No ❏ Yes If yes, how much per week? ________________________________

10. Do you live ❏ Alone ❏ With family/friends ❏ In an assisted living facility ❏ Other ________________

11. Who provides your primary support? ________________________________

12. Are you a caregiver? ❏ No ❏ Yes If yes, check all that apply:
    ❏ Spouse ❏ Parent ❏ Children ❏ Other: ________________________________

13. Do you have concerns about this visit? ❏ No ❏ Yes
    If yes, please describe: ________________________________

14. Do you feel you have been physically or emotionally abused or neglected? ❏ No ❏ Yes ❏ Unsure

15. Our care is often provided in a common area. Do you request any additional accommodations to maintain your privacy and confidentiality? *(If applicable)* ❏ No ❏ Yes If Yes, please explain: ________________________________
    ____

16. Please grade/mark your pain. ❏ NO PAIN ❏ PAIN – Pain Scale: (least) 1 2 3 4 5 6 7 8 9 10 (worst)

    What increases your pain?

    ____

    What decreases your pain?

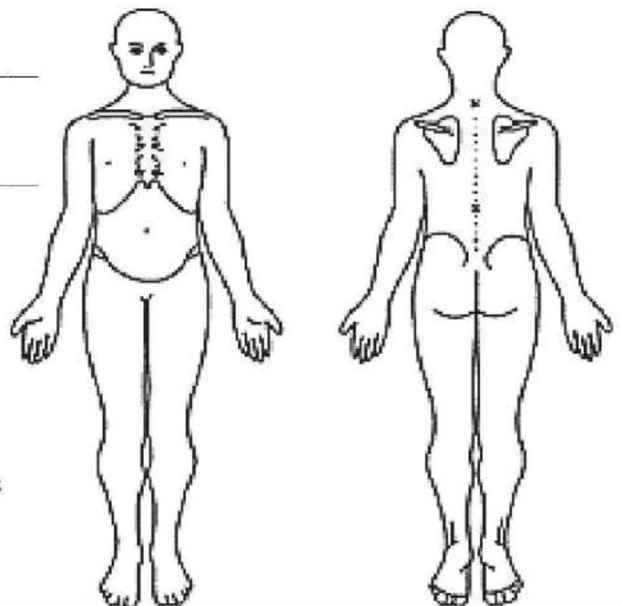
    ____

    Describe your pain:

    ❏ Sharp ❏ Dull ❏ Burning ❏ Aching
    ❏ Crushing ❏ Numbness ❏ Tingling ❏ Radiating
    ❏ Tight ❏ Soreness ❏ Other:

    Does your pain keep you up at night? ❏ No ❏ Yes

    Does your pain increase with a cough or sneeze? ❏ No ❏ Yes



Patient Name: ________________________________ Patient DOB: ____________

17. Medicine: (include vitamins, herbs, over-the-counter medicines)* ❑ None taken

Medicine	Dose	How Often	Reason	Time Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				

18. Allergies: (include medicine, food, latex, tape, iodine, etc)* ❑ No allergies

What are you allergic to?	What kind of allergic reaction did you have?
1.	
2.	
3.	
4.	

19. List all of your doctors:

Doctor's Name	Doctor's Specialty
1.	
2.	
3.	
4.	
5.	
6.	
7.	

20. List and date ANY surgeries or hospital admissions you have had: ❑ None

Surgery, Reason and Date
1.
2.
3.
4.
5.
6.

*ATTACH AND USE AMBULATORY SERVICES SUMMARY LIST FOR SUBSEQUENT UPDATES EACH VISIT TO MEDICATIONS, ALLERGIES, HOSPITALIZATIONS, SIGNIFICANT OPERATIONS/ PROCEDURES AND DIAGNOSIS/CONDITIONS.

Continued on next page

Patient Name: ______________________ Patient DOB: __________

21. May be completed by patient, family, companion or staff. For each condition, please check YES or NO.

Heart	Yes	No
1. Abnormal EKG		
2. Angina		
3. Chest pain		
4. Heart attack		
5. Heart disease		
6. Heart murmur		
7. High blood pressure		
8. Low blood pressure		
9. Pacemaker or defibrillator		

Lungs*	Yes	No
10. Abnormal chest X-ray		
11. Asthma		
12. Collapsed lung		
13. Chronic Obstructive Pulmonary Disease		
14. Cough		
15. Cough over two weeks		
16. Cystic fibrosis		
17. Emphysema		
18. Pneumonia		
19. Shortness of breath		
20. Tuberculosis or a positive skin test		

Diabetes*, Thyroid*	Yes	No
21. Diabetes		
22. Hypoglycemia (low blood sugar)		
23. Thyroid disease		

Stomach, Liver, Intestines*	Yes	No
24. Cirrhosis		
25. Constipation		
26. Diarrhea		
27. Hepatitis – A B C		
28. Jaundice		
29. Nausea or vomiting		
30. Ostomy		

Blood/Immune System*	Yes	No
31. Anemia		
32. Blood disorder		
33. Bruises		
34. Cancer		
35. Cold or sore throat		
36. Fever		
37. Hemophilia		
38. HIV/AIDS		
39. Immune deficiency		
40. Night Sweats		
41. Recent infection		
42. Sickle cell anemia		
43. Swollen glands		
44. Skin rash		

Other (list)*	Yes	No
Do you have a/an:		
45. I.V. access device		
46. Prosthesis — artificial leg, arm, other part		
47. Medicine pump		

Brain, Bones, Nerves*	Yes	No
48. Arthritis		
49. Back trouble		
50. Broken face bones		
51. Dizziness		
52. Fractures (broken bones)		
53. Gout		
54. Headache		
55. Head injury		
56. Joint pain		
57. Joint stiffness		
58. Memory loss		
59. Muscle weakness		
60. Recent falls		
61. Seizure disorder		
62. Stroke		

Genitourinary/ Gynecological*	Yes	No
63. Bleeding		
64. Burning on urination		
65. Dialysis		
66. Kidney problems		
67. Prostate problems		
68. Pregnant		
69. Urinary/fecal incontinence		

General*	Yes	No
70. Alcohol or chemical dependency		
71. Very large weight loss		
72. Anxiety		
73. Depression		

Person completing this health history:

❏ Patient ❏ Family/significant other ❏ Health care staff

Signature:______________________________ Date:______________

Patient Name: ______________________________ Patient DOB:______________