Elaine Mele, PT, DPT, PYT

Move well. Live Well.

Personal Information

Name: DOB:

Address:

Home Number: Cell Number:

Email Address:

Preferred Method of Contact (circle): email home cell other:

Emergency Contact:

Name:

Phone:

Relationship:

Physician:

Address:

Phone:

License Numbers: CA 40161, DC 872326, MT 13058, NY 020824, WA 60806209

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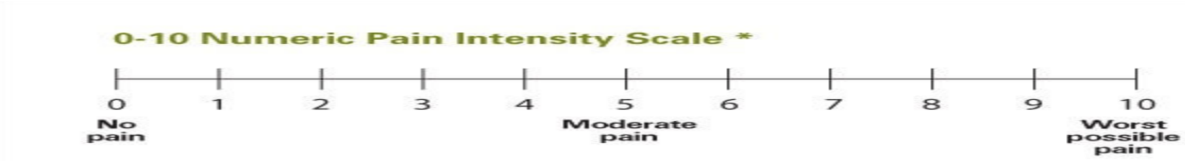
Current Medical Complaints

Areas of Concern:_____

Do you have pain? **Y / N** If Y, how long (days/months/years) _____

Severity: Indicate a number **0 (none) -10 (worst)** Best:_____ Worst:_____ Average:_____



What makes the pain better? _____What makes it worse? _____

The pain is worst in the Morning/Afternoon/Evening

Quality: Achy/Burning/Dull/Numb/Sharp/Tingling/ Other:_____

Additional details, incl test results, past treatments and whether or not they were successful:

_____

_____

_____

Significant Past Medical History

Hospitalizations: _____

Surgeries: _____

Allergies: _____

Medications: _____

_____

Supplements: _____

(Check all that apply)

Accidents/Falls: __ Never __Past Year __ Past 5 Years __ Over 5 Years

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Family History: __ Cancer __Diabetes __ Heart Disease __ Lung Disease

__ Thyroid Disease __ Allergies __ Arthritis __ Stroke __ Hypertension

__ Mood Disorders __ Eating Disorders __ Other: _____

Review of Systems

Have you ever had any of the following diseases or conditions? (Check all that apply):

__ Arthritis __ Vertigo __ Chronic Fatigue __ Heart Attack __ TBI __ Mood Disorder

__ Diabetes __ Epilepsy or Seizures __ Anemia __ Cancer, Type:_____

__ Cardiac Arrhythmia __ Kidney Stones __ Stroke / CVA __ Hypo/HyperThyroid

__ Blurred Vision __ Migraines __ Shingles __ Tuberculosis (TB) __ Autoimmune disorder

Please add detail, if applicable:_____

Musculoskeletal System:

__ Neck Pain __ Low Back Pain __ Surgeries:_____

__ Joint Pain/Stiffness __ General Stiffness __ Radiating Leg Pain __ Difficulty Walking

__ Difficulty Chewing/Clicking Jaw ___ Warm, Red or Swollen joints __ Fractures: _____

Nervous / Cognitive Systems:

___ Anxiety __ Dizziness/ Vertigo __ Chronic Stress __ Depression

___ Panic Attacks __ Fainting __ Forgetfulness __ Confusion

___ Feelings or history of self-harm __ Physical or Sexual Trauma

Gastro-Intestinal System

__ Poor Appetite __ Excessive Hunger __ Excessive Thirst __ Frequent Nausea

__ Vomiting __ Diarrhea __ Hemorrhoids __ Gall Bladder Problems

__ Colitis /IBS __ Gas/Bloating __ Heart Burn __ Black/Bloody Stool

Genito-Urinary System:

__ Incontinence __ Painful Urination __ Excessive Urination __ Discolored Urine

__ Prostatitis __ Prolapse

CardioVascular System:

__ Chest Pain __ Shortness of Breath __ Edema __ Hypertension

__ Irregular Heartbeat __ Stroke __ Varicose Veins __ CHF

__ Pacemaker

Ears/Eyes/Nose/Throat:

__ Vision Problems __ Dental Problems __ Sore Throat __ Ear Aches

__ Hearing Difficulties __ Congestion __ Sinus Problems __ Coughing

__ Discolored Sputum/Nasal Discharge

Reproductive System:

Female:

__ Menstrual Irregularities __ Menstrual Cramps __ Vaginal Pain/Infection __ Breast Tenderness

__ Frequent UTIs __ Miscarriage __ Menopause

Date of Last Period? _____ Are you pregnant: Yes/No How many weeks: _____

# of pregnancies_____

Male:

__ Prostate Hypertrophy or Cancer __ Sexual Dysfunction __ Other: _____

Additional History:

_____

_____

_____

Social History

Occupation: _____

What is your stress level? _____ 0 (none) -10 (unbearable)

How do you typically manage your stress: _____

Avg # hrs of sleep/ night_____ Do you have difficulty sleeping? Yes/No

Do you exercise? (circle) : None / Rarely / 1-3x week / 3-5x week / Daily

What type of exercise do you enjoy / perform? _____

Do you smoke? Yes/No If yes, how many packs per day? _____

Do you drink alcoholic beverages? Never / Rarely / 1-3x week / 3-5x week / Daily / Socially

Drug use? Never / Rarely / 1-3x week / 3-5x week / Daily / Socially

Favorite leisure activities: _____

What are you currently not able to do that you wish you could?

_____

In your own words, what is your goal for physical therapy?

_____

Thank you for taking the time to provide us with a comprehensive and accurate history!!

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