



CATALYST

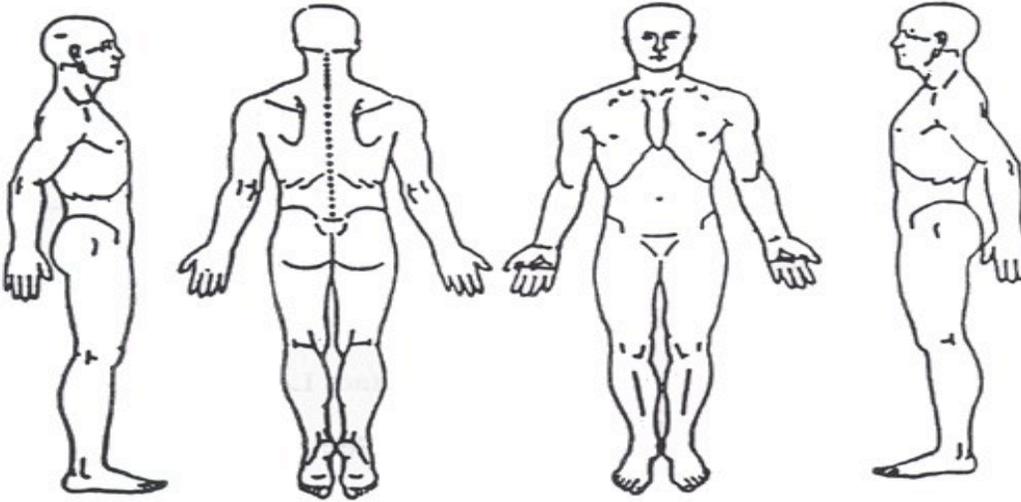
PHYSICAL THERAPY & WELLNESS

Client Health Information

Patient Name: _____

Please describe the current issue that brings you in today, including date of onset: _____

Please mark below areas of pain, irritation, tension or stress to be addressed:



For the previously mentioned issue, please do you best to describe the pain: (dull, sharp, ache, throb, shooting): _____

Please mark where your pain is at its best and worst, 0 = no pain and 10 = debilitating pain

Best: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

Are you currently under a physicians care for this issue? Y____ N____

If yes please explain: _____

Are you seeking any other treatment for your current concern? Y____ N____ If yes, please list the service and the last date of treatment. (acupuncture, chiropractic, personal training, massage) _____

Are you currently taking any prescribed medication or supplements? Y____ N____

Please provide a list to keep on file or list here: _____

Goals for your treatment: _____



CATALYST

PHYSICAL THERAPY & WELLNESS

Medical History

Please mark an (X) by all current conditions and (P) for past conditions

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdominal /digestive problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis/tendonitis | <input type="checkbox"/> Headaches, migraine | <input type="checkbox"/> Rash/fungus |
| <input type="checkbox"/> Asthma or breathing conditions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Athletes foot | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Bowel and Bladder issues | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Spinal Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaw pain/TMJ | <input type="checkbox"/> Sprain/strain |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory/ heart problems | <input type="checkbox"/> muscle/bone injuries | <input type="checkbox"/> Tension/stress |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Weight loss (unintentional or excessive) | |

Elaborate on noted areas above: _____

Please list any recent injuries or surgeries within the past 5 years: _____

Please list any other pertinent information regarding your medical history: _____
