OMAHA PHYSICAL THERAPY INSTITUTE, P.C.

Patient Health History

Patient Name:_____Date:_____

1. **What is your status? (Circle answer and if not employed, skip to question 5)**
   a. Employed (If so, what is your occupation? _____)
   b. Unemployed c. Student d. Retired e. Homemaker f. Disabled

2. **If employed, are you (circle)**
   a. Working your normal job without restrictions
   b. Working in your normal job with restriction (Please Explain)_____
   c. Working in an alternate job
   d. Currently not working due to your present injury/impairments

3. **What are your primary job tasks? (Circle all that apply)**
   a. Prolonged sitting
   b. Prolonged standing
   c. Lifting
   d. Repetitive tasks (like computer, writing, phone work, assembly)
   e. Operating a machine
   f. Driving
   g. Other_____

4. **Please circle any of the following health conditions that you now have or had in the past. (Circle)**

a. None	k. Unexplained weight loss	u. Tuberculosis
b. Cancer	l. Seizures	v. Kidney disease
c. Diabetes	m. Chemical dependency	w. Anemia
d. High Blood Pressure	n. Smoker	x. Stroke
e. Heart problems	o. Currently Pregnant	y. Osteoporosis
f. Rheumatoid arthritis	p. # of pregnancies_____	z. History of fractures
g. Osteoarthritis	q. Mental Illness	aa. Menopausal
h. Asthma	r. Thyroid disease	bb. Incontinence
i. Emphysema	s. Multiple Sclerosis	cc. Depression
j. Overweight	t. Hepatitis	dd. Other_____

5. **Please circle any medications that you are taking (over the counter and prescription). (Circle)**

a. None	f. Anti-depressants	k. Thyroid Hormone
b. Anti-Inflammatory	g. High Blood Pressure Medications	l. Heparin/Coumadin
c. Pain Medications	h. Heart Medications	m. Meds to increase bone density
d. Muscle relaxants	i. Hormone replacement therapy	n. Other_____
e. Steroids	j. Anti-seizure medications	

   ***Please list any allergies you have**:_____

6. **Please list any surgeries you have had and the date performed:**_____
   _____
   _____