Desert Physical Therapy
& Women's Health Center, LLC
4545 E. Shea Blvd. Suite 168
P: (602)264-3369

GENERAL HEALTH HISTORY:

NAME: _____ DATE: _____

Reason for physical therapy:_____

Please list any current medications and/or allergies:_____

_____

Please indicate if you have or have had any of the following:

Condition	**Yes**	**No**	**Describe/When**
Asthma	☐	☐	_____
Arthritis	☐	☐	_____
Blood Problem	☐	☐	_____
High Blood Pressure	☐	☐	_____
Cancer	☐	☐	_____
Depression/Anxiety	☐	☐	_____
Diabetes	☐	☐	_____
Heart/Lung	☐	☐	_____
Muscle, Joint, Bone	☐	☐	_____
Stomach	☐	☐	_____
Stroke/TIA	☐	☐	_____
Urinary/Gynecologic	☐	☐	_____

Surgery	**Yes**	**No**	**Describe/When**
Abdominal	☐	☐	_____
Bladder	☐	☐	_____
Uterine	☐	☐	_____
Bowel	☐	☐	_____
Orthopedic	☐	☐	_____
Spine	☐	☐	_____
Heart	☐	☐	_____
Lungs	☐	☐	_____
Plastic	☐	☐	_____
Other	☐	☐	_____

For Women Only:			
Vaginal delivery	☐	☐	_____
Caesarian delivery	☐	☐	_____
Menopausal changes	☐	☐	_____
Currently pregnant	☐	☐	If yes, when is your due date:_____

Please indicate your level of pain below:

_____

0 — No Pain

10 — ER Visit

Please indicate your level of stress below:

_____

0 — No Stress

10 — Extreme Stress