Oregon Neurosport Physical Therapy
Patient Health History

Patient Name:_____

Diagnosis:_____

Have you been treated for this condition before? _____YES_____NO

Please check any information that may be pertinent to help us provide the best Physical Therapy care possible.

Have you or a family member had or have received treatment for the following;

Heart Disease	**_____You**	**____ Family**
Hypertension	**_____You**	**____Family**
Diabetes	**_____You**	**____Family**
Seizure Disorder	**_____You**	**____Family**
Hepatitis	**_____You**	**____Family**
HIV/AIDS	**_____You**	**____Family**
Emphysema	**_____You**	**____Family**
Asthma	**_____You**	**____Family**
Arthritis	**_____You**	**____Family**
Cancer	**_____You**	**____Family**
Chronic Obstructive Pulmonary Disease (COPD)	**_____You**	**____Family**
Steroid Use (Prednisone)	**_____You**	**____Family**

Any Other Pertinent Medical Condition_____

Please circle your current level of pain on a (0-10) scale
0 = no pain, 10 = severe pain 0 1 2 3 4 5 6 7 8 9 10

Thank You for taking the time to fill out this Health History Form

Patient Signature:_____**Date:**_____