



BodyWise Physical Therapy - Fitness
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PATIENT HISTORY FORM

[Please fill out in detail and ask us for help any time if you have questions]

Name: _____ Date of birth: _____

Allergies: _____

Medications: _____

Which diagnostic tests were done? _____

Where is your pain? _____

When did it start (date)? _____ How did it start? Sudden Gradual Slow

Rate your pain from 0 = none to 10 = most:

At best _____ On average _____ At worst _____

Do you have any previous history / treatment for your condition? Please list:

Check all that apply to your medical history:

Heart disease Cancer Pacemaker Hepatitis HIV/AIDS Arthritis/RA

Osteoporosis Diabetes Asthma Pregnancy Tuberculosis COPD/Lung

What functional limitations do you have due to your pain? Please describe

What work limitations do you have due to your condition? Please describe

What specific goals do you want to accomplish with therapy if different from your limitations [eg: resume golfing... quilting... team sports...]

To the best of my knowledge, the information I have given is true and complete. I consent to receive therapy services at BodyWise Physical Therapy-Fitness:

Patient Signature _____ Date: _____