Specialized Physical Therapy
Moving You Forward

T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main Street STE 3, North Reading, MA 01864

SPT Health History Form – Page 1/2

Welcome to our practice and thank you for choosing Specialized Physical Therapy (**SPT**) for your premium Physical Therapy (**PT**) Services. We are passionate about our practice and committed to providing you and your family with the highest quality of care. We look forward to the opportunity to restore your health to its maximum potential. If you have *any questions or concerns*, please call our clinic and our staff will be happy to assist you.

1. Please describe your **PRIMARY** injury: _____

_____

2. What caused your injury? _____

_____

3. When did it start? _____

4. What makes you feel better? _____

5. What makes your problem worse? _____

6. When are your symptoms worse?
Morning ☐ Afternoon ☐ Evening ☐ As the days goes on ☐ Same all day ☐

7. In the past, have you been treated for the same problem? Yes ☐ No ☐ At what clinic? _____

If yes, what else have you tried? _____

_____

8. What are your **GOALS** for physical therapy? _____

9. What is your occupation? _____ Are you working now? Yes ☐ No ☐

10. What are your hobbies? _____

11. According to the scale below, please indicate your worst pain level over the past couple of days:

No Pain Mild Moderate Severe Excruciating Have you been to the E.R: Yes ☐ No ☐
0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10 Pain Level: _____

12. Please list any other conditions: _____

_____

13. Please list all medications (or bring a typed list) you are currently taking and what they treat: _____

_____

_____

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14. Allergies: _____

_____

15. Please list all relevant surgeries with dates: _____

_____

_____

16. Do you have a regular exercise program? Yes ☐ No ☐

If yes, please describe: _____

17. Please complete your medical history below: *If you ever had an injury or medical condition in the past, please check the PAST column. If you are presently troubled by an injury or medical condition, please check the PRESENT column. The information you provide concerning past and present conditions and diseases help your therapist in more thoroughly understanding your state of health.*

Past: ☐	Present: ☐	High blood pressure	Past: ☐	Present: ☐	Blood disorders/Clots
Past: ☐	Present: ☐	Heart attack	Past: ☐	Present: ☐	Breathing problems/Asthma
Past: ☐	Present: ☐	Chest pain/Heart palpitations	Past: ☐	Present: ☐	Broken bones
Past: ☐	Present: ☐	Pacemaker/Defibrillator	Past: ☐	Present: ☐	Osteoporosis
Past: ☐	Present: ☐	Diabetes	Past: ☐	Present: ☐	Stomach/GI problems
Past: ☐	Present: ☐	Cancer or tumors	Past: ☐	Present: ☐	Head injury
Past: ☐	Present: ☐	Stroke	Past: ☐	Present: ☐	Seizures
Past: ☐	Present: ☐	Osteoarthritis	Past: ☐	Present: ☐	Anxiety
Past: ☐	Present: ☐	Rheumatoid Arthritis	Past: ☐	Present: ☐	Depression

The patient or parent/legal guardian must provide **ACCURATE, TRUE, COMPLETE, and TIMELY** insurance, billing, third party, and health history information, determine whether our services are covered under your insurance plan, and ensure all insurance, attorney, and third party requirements are met for your plan prior to and throughout treatment. By signing your name on page two of this document and choosing Specialized Physical Therapy, LLC for physical therapy treatment, the patient or parent/legal guardian **certifies** that the *undersigned* **has read, fully understands, and agrees** with all company terms, is ALWAYS primarily liable for any and all unpaid account balances for services rendered, and agrees to pay account balances in full when due; furthermore, if insurance (i.e. health, auto, or workers' compensation) rather than cash is chosen for payment and claims have been fully or partially rejected, denied, or unpaid for **ANY REASON**, the patient or parent/legal guardian agrees to pay IN FULL for services rendered. Policy for patients considered minors (UNDER 18 YEARS OLD): The parent/legal guardian of a patient who is considered a minor is responsible for full payment.

PATIENT NAME (*Print or Type*): _____

PARENT or LEGAL GUARDIAN Name (*Print or Type*): _____

PATIENT or PARENT / LEGAL GUARDIAN **SIGNATURE**: _____ **Date:** _____