HODGES
PHYSICAL THERAPY

CLIENT HEALTH INFORMATION

Please complete this form and bring with you on your initial consultation.

FIRST NAME _____ LAST NAME _____

Preferred Pronoun: ◯ She/Her ◯ He/Him ◯ They/Them

When was your last physical with your primary care provider? _____

How would you rate your overall health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

During the past month, have you been feeling down, depressed or hopeless? ◯ Yes ◯ No

Do you have a history of trauma that you would like Cheri to be aware of? ◯ Yes ◯ No

Have you fallen in the last 3 months? ◯ Yes ◯ No

Medical Health Information

Please provide a history of medical conditions and surgeries:

_____

_____

_____

_____

Please list your current medications:

_____

_____

Have you recently experienced any of the following: (please check)

Chest Pain: ◯ Yes ◯ No
Light Headedness: ◯ Yes ◯ No
Shortness of Breath: ◯ Yes ◯ No
Difficult Breathing: ◯ Yes ◯ No
Nausea: ◯ Yes ◯ No
Vomiting: ◯ Yes ◯ No
Difficulty Urinating: ◯ Yes ◯ No
Blood in Urine: ◯ Yes ◯ No
Excessive Thirst: ◯ Yes ◯ No
Excessive Hunger: ◯ Yes ◯ No

Abnormal Sensations (ie: numbness, pins and needles or burning): ◯ Yes ◯ No
Weakness: ◯ Yes ◯ No
Changes in skin color: ◯ Yes ◯ No
Changes in skin texture: ◯ Yes ◯ No
Night pain: ◯ Yes ◯ No
Pain with Rest: ◯ Yes ◯ No
Infection: ◯ Yes ◯ No

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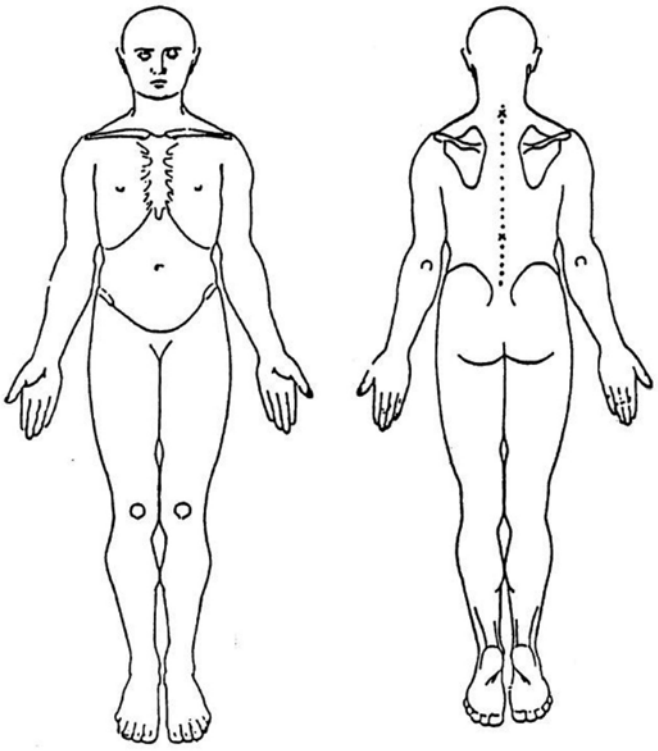
Provide details of your current symptoms (ie pain, weakness, tingling, numbness) and where they are coming from on this body chart:



27424 North 75th Way, Scottsdale, AZ 85266 | 480.849.2437 | Cheri@HodgesPT.com | HodgesPT.com