Gritman THERAPY SOLUTIONS

Health History Form

Legal Name:	**DOB:**	**Gender:**

Are you currently under the care of:
- ☐ MD
- ☐ Chiropractor
- ☐ Massage Therapy
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Home Health

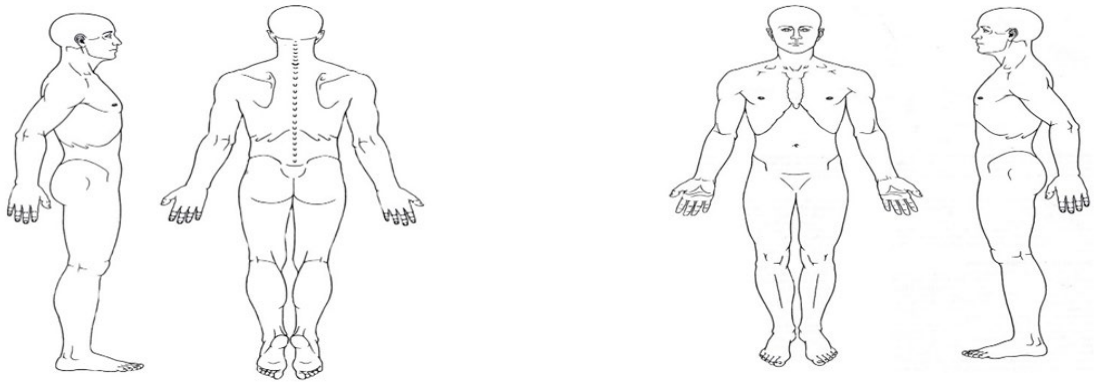
Referring Physician:

Primary Care Physician:

Have you had any tests for this injury?
- ☐ X-ray
- ☐ MRI
- ☐ Other:_____

Medical Diagnosis/ Reason for coming to therapy:

Please Shade the area(s) of pain



PAIN SCALE: 0=NO PAIN, 10=WORST PAIN Select Level

Please Check all that apply:
- ☐ Stroke/TIA
- ☐ Heart Problems
- ☐ Blood Pressure Problems
- ☐ Pacemaker/Defibrillator
- ☐ Fainting
- ☐ Dizziness/Vertigo
- ☐ Bladder Problems
- ☐ Lung/Breathing Problems
- ☐ Cancer
- ☐ Weight Change
- ☐ Diabetes
- ☐ Gastrointestinal Problems
- ☐ Bowel Problems
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Depression/ Anxiety
- ☐ Arthritis Type_____
- ☐ Tobacco Use_____ times per day
- ☐ Alcohol Use _____ times per day
- ☐ Drug Use _____ times per day
- ☐ Other:_____

Please List significant accidents, surgeries, medical conditions, infectious or communicable diseases:

When did this first occur and what brought it on?

What activities/movements make it worse? What makes it better?

Is the condition getting worse? Yes ◯ No ◯

Does it interfere with: (check all that apply)
- ☐ Work
- ☐ Sleep
- ☐ Daily Activities
- ☐ Recreation

What are your expectations from therapy?

Health History Form

Patient Name: _____ DOB:_____

If you have a copy of your medication list with you please give to office staff and disregard this page.

Please list all prescribed medications and over the counter medications you are currently taking.

MEDICATION LIST

Medication	Dose	How often	Prescribing provider

ALLERGIES:

(Please list any medications, foods, and/or materials you are allergic to and the reaction you had)

Allergic to	Reaction

Gritman Therapy Solutions
810 S. Main St.
Moscow, ID 83843
Phone: 208-883-1522
Fax: 208-883-6452

Attendance Policy

Cancelations:

In the event that you need to cancel your appointment, please call (208)883-1522 as soon as you know that you are unable to make it.

Initial Evaluations:

You are expected to arrive and check in for appointments 15 minutes prior to your scheduled appointment to allow time for registration and clinical staff intake.

Aquatic Patients:

Please arrive 15 minutes prior to your scheduled appointment to give you time to change for the pool.

No Shows:

If you have not given proper 24 hour notice with the exception of sickness we follow the guidelines listed below:

- First and second No show/Late cancelation- you will receive a warning letter explaining our policies and procedures and requesting compliance.
- Third and Subsequent No show/Late Cancelation- Final warning and/or termination letter and healthcare provider-patient relationship letter will be sent to you or your representative/guardian.

New Patients:

If you No Show your first 2 appointments you will not be accepted into therapy as a patient.

Late Arrivals:

If you arrive more than 10 minutes after your appointment time the Front Office Staff will consult with your therapist to determine if there is time to complete your appointment.

Sick Policy:

We value the health and safety of our patients and staff and ask that if you are sick (fever, vomiting, cold/flu like symptoms) to please cancel your appointment as will our staff to ensure your health and safety.

Please sign below acknowledging that you have read and will adhere to our policies and procedures:

Signature_____ Date_____

Relationship to patient_____