





Willow Physical Therapy, LTD  
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## PATIENT'S HISTORY for FEMALE CONDITIONS

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation \_\_\_\_\_ (Patient initials)

Medication	Dosage	Reason for Taking

*Use additional sheet if more space is needed*

### Where do you currently live (or intend to live) at the conclusion of your episode of therapy?

Private Home  Private Apartment  Rented Room  Group Home  Assisted Living  Skilled Facility  Other

### Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

Live Alone  Spouse/Significant Other  Child/Children  Other Relative  Personal Care Attendant  Other

**Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.):** \_\_\_\_\_

**What are your goals for your course of physical therapy?** \_\_\_\_\_

**At the present time, would you say your health is excellent, very good, fair, or poor?** \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Evaluating Physical Therapist Signature

\_\_\_\_\_  
Date