

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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



Returning patients only: Review and update (initial and date): \_\_\_\_\_

To evaluate your condition fully, please complete the questions as accurately as possible. Thank you!

1. What is your primary complaint that brings you here? \_\_\_\_\_

2. When did your symptoms begin or worsen (date)? \_\_\_\_\_

3. Have you had surgery for this injury? Yes No If yes, when? \_\_\_\_\_

4. What caused your symptoms to begin or injury to occur? \_\_\_\_\_

5. Currently, are any of your daily or recreational activities affected? Yes No If yes, how? \_\_\_\_\_

6. What makes your symptoms worse (positions/activities/time of day)? \_\_\_\_\_

7. What improves your symptoms? \_\_\_\_\_

8. Prior to onset of your symptoms:

Did you have any limitations with activities, or require physical assistance? Yes No

If yes, please explain: \_\_\_\_\_

Were you physically active on a regular basis? Yes No

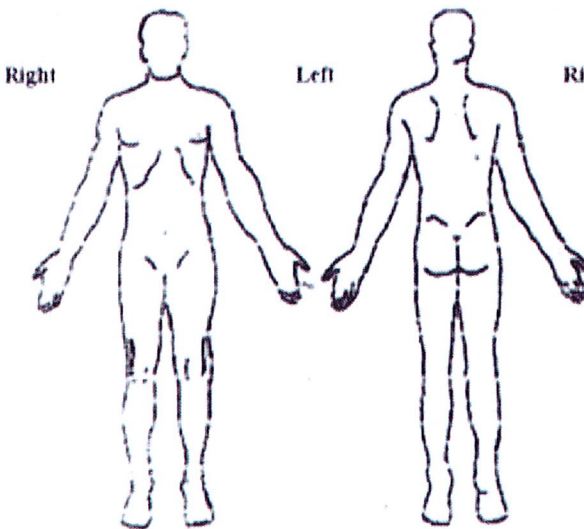

If yes, list primary activities: \_\_\_\_\_ How often? \_\_\_\_\_

9. Have you had these symptoms before? Yes No

a. If yes, did you receive any treatment? Yes No Did the treatment help? Yes No

What did the treatment consist of? \_\_\_\_\_

10. What are your goals for physical therapy? (pain, activities, movement, preparation for event, etc.)

11. Where is your pain? Please draw on body diagram	12. Please rate and describe your pain
	 <p>Please rate your pain on a scale of 0-10</p> <p>Worst pain in last week: /10</p> <p>Current pain: /10</p> <p>At best: /10</p> <p>My symptoms bother me:</p> <ul style="list-style-type: none"><li>• Constantly</li><li>• Most of the time</li><li>• Occasionally</li></ul> <p>My pain is (circle all that apply):</p> <p>Sharp Stabbing Shooting Throbbing</p> <p>Burning Aching Other _____</p> <p>My pain is getting:</p> <p>Better Worse Staying the same</p>

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13. Past Medical History (circle all that apply):

Diabetes Type I or II  
Current smoker  
Former smoker  
Hepatitis A B C  
Lung problems  
High Blood Pressure  
High Cholesterol  
Chest pain/Angina  
Pacemaker  
Anemia  
Lightheadedness/dizziness  
Hypoglycemia

Epilepsy/Seizures  
Balance disorder/Vertigo  
Chronic Headaches/Migraines  
TMJ disorders  
Head injury  
Stroke  
Circulation/Vascular problems  
Bleeding/bruising  
Blood disorders  
Spinal Cord Injury  
Polio/muscle disease  
Lyme's Disease

Depression  
Anxiety  
Pregnant or possibly pregnant  
Gynecological disorders  
Thyroid problems - hypo or hyper  
Fibromyalgia  
Chronic Fatigue Syndrome  
Osteoporosis  
Arthritis/joint pain  
Hernia  
Kidney Disease  
Fainting Disorders

Cardiac/Heart Condition: (describe) \_\_\_\_\_

Respiratory Problems: (describe) \_\_\_\_\_

Fractures (describe): \_\_\_\_\_

Cancer: (describe) \_\_\_\_\_

**Any other chronic illnesses or conditions?**

14. **List surgeries / major injuries and dates** for which you have been treated, including fractures, dislocations, joint replacements, etc. (continue on lower margin if more space is needed)

15. Currently, I am experiencing (circle all that apply):

Numbness/Tingling  
Depression/Anxiety  
Difficulty swallowing  
Fever/Chills/Sweats  
Nausea/Vomiting

Headaches  
Changes in appetite  
Weakness  
Swelling  
Shortness of breath

Unexplained weight change  
Poor balance/dizziness  
Pain that worsens at night  
Changes in bowel/bladder function  
Loss of motion

16. Have you had **diagnostic tests** for this problem? (x-ray, MRI, CT scan, Bone Scan, Ultrasound, lab tests)

If so, what were the results? \_\_\_\_\_

17. **List medications** you are currently taking (including pills, injections, and/or skin patches). **MEDICARE only:** Please list medications, dosages as well as frequency. If you have a medication list with all the necessary info, we will make a copy.

18. What is your current weight? \_\_\_\_\_ lbs    19. What is your current height? \_\_\_\_\_ feet \_\_\_\_\_ inches

20. What does your blood pressure normally run at? \_\_\_\_\_ Systolic (top #) \_\_\_\_\_ Diastolic (lower #)

18. **List allergies:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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

Relationship is other than patient/ Parent / Guardian if minor: \_\_\_\_\_

**This information will be used as a guide in your treatment plan. If you need any medical follow-up, please contact your physician.**