Today's Date:

ENCORE PHYSICAL THERAPY

First Name: _____ MI: _____ Last Name: _____

DOB: _____/____/_____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Emergency Contact: _____ Phone Number: _____-_____-_____

Primary Care Provider: _____

Primary Insurance: _____ ID #: _____

Policy Holder: _____ DOB: _____/____/_____

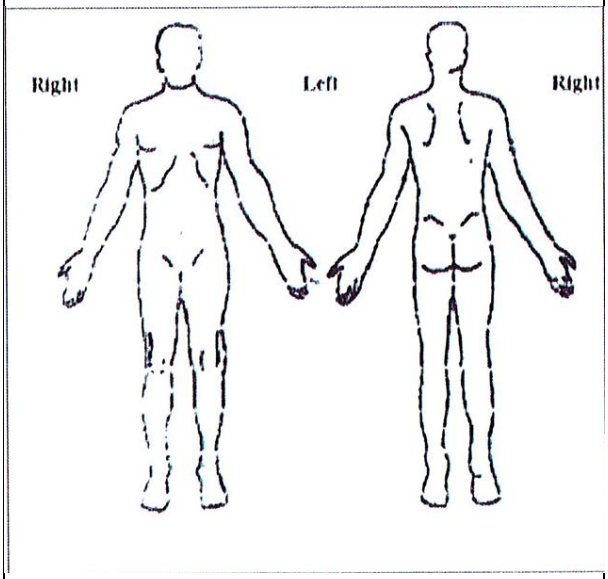
Secondary Insurance_____ ID #: _____

Policy Holder: _____ DOB: _____/____/_____

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

1. When did your symptoms start (date)? ____/____/_____
2. Briefly describe your symptoms: _____
   _____
3. What caused your symptoms? _____
   _____
4. Prior to onset of symptoms:
   a. Did you have any limitations with activities/exercise (circle)? Yes No
      i. Describe: _____
   b. Were you physically active on a regular basis (circle)? Yes No
      i. Type and frequency of activity: _____
5. Have you had these symptoms before (circle)? Yes No
   a. If yes, did you receive treatment? Yes No
      i. Did treatment help? Yes No
   b. What did treatment consist of? _____
6. Have you had surgery for this injury? Yes No Date of surgery: _____
7. What are your goals for physical therapy? (pain, activities, movement, etc.):
   _____
   _____

8. Please circle where your pain is on the diagram and your answers to the following questions:



Average Pain Intensity (0- no pain 10-worst pain)

Last 24 hours:

0 1 2 3 4 5 6 7 8 9 10

Past week:

0 1 2 3 4 5 6 7 8 9 10

How often do you experience these symptoms?

Constantly Frequently
Occasionally Intermittently

How much have your symptoms interfered with daily activities?

Not at all Little bit Moderately
Quite a bit Extremely

How would you describe your overall health?

Excellent Very Good Good Fair Poor

9. Past Medical History (circle):
    a. Cardiac / Respiratory / Fractures / Cancer / Pacemaker / Epilepsy
    b. Describe: _____

    Other chronic illness or condition: _____

    _____
10. Medications: _____

    _____
11. Previous surgeries, major injuries, and dates: _____

    _____
12. Currently I am experiencing (circle all that apply):

    Numbness/Tingling Headaches Weakness Swelling

    Pain that worsens at night Dizziness Poor Balance Loss of motion
13. Have you completed diagnostic tests or imaging for this issue? _____

    _____

Patient signature: _____ Date: _____/____/_____

Relationship other than patient/parent/guardian (for minors): _____