Name ___________________________________ **Date** ____/____/____

PLEASE COMPLETE ALL REQUESTED INFORMATION

1) Have you ever had physical therapy for the same condition for which you are here today?
YES/ NO
If so, where and when?

2) Please List your: **Height**:______ **Weight**: ______
Age: ______
3) Briefly **describe** your present symptoms:

When did your symptoms start? (MM/DD/YY)
______/_______/_______
How did your symptoms start?

4) List any **medications** you are now taking (***please let the office know if you have a list to copy***)

5) Please list any recent **diagnostic studies** (eg. X-ray, MRI, CAT scan, blood work) ***particularly*** as related to your present problem and ***where taken***

6) Do you have **metal** anywhere in your body, i.e. pins, plates, pacemaker, etc (except teeth)? If yes, please describe:

7) Are you now **pregnant**? **YES /NO**

8) List any **allergies** you have:

9) List any **surgeries** with approximate dates:

10) Have you had any falls in the last year?

11) Circle any **medical conditions** we should be aware of:

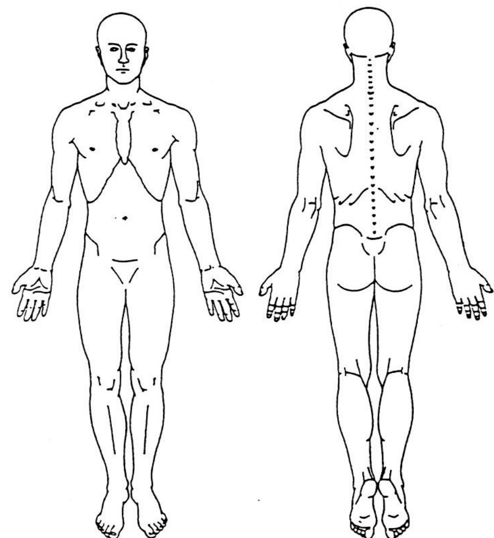
High blood pressure	Seizures	Diabetes	Dizzy spells
Heart or circulation disorders	Osteoporosis	Pacemaker	Thyroid
Arthritis/osteoarthritis	Cancer	Breathing Difficulties	Other or explain the above:

12) On the body diagram to the right, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.

13) Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

1	2	3	4	5	6	7	8	9	10

None — Worst imaginable



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14) Average Pain Intensity

Last 24 Hours (1 thru 10):

Past Week (1 thur 10):

15) How often do you experience symptoms?

A) Constantly (76-100% of the time)
B) Frequently (51-75% of the time)
C) Occasionally (26-50% of the time)
D) Intermittently (0-25% of the time)

16) What is your goal for therapy at this time?

17) How much have your symptoms interfered with your daily activities?

A) Not at all
B) A Little Bit
C) Moderately
D) Quite a bit
E) Extremely

18) How would you say your overall health is right now?

A) Excellent
B) Very Good
C) Good
D) Fair
E) Poor