Name: _____ **DOB:** ___/____/_____

Today's Date: ___/____/_____ **How did you hear about us?** _____

Current Condition

What is the nature of your pain or problem? _____

_____

When did you first notice your pain/symptoms? (**Please list a specific date**) _____/_____/____

Is this injury/condition work related? YES NO

Is this injury/condition a result of a motor vehicle accident? YES NO

Is this injury/condition a result of sports participation? YES NO What sport/position? _____

How did your symptoms occur? _____

_____

How many of days of work you have missed due to this injury/condition? _____

Are you taking **ANY** medication (prescription or over-the-counter)? Please list here: _____

_____

Past Medical History

Have you **EVER** been diagnosed with the following? **(Please indicate yes or no with a √ in the box under YES or NO)**

Cardiovascular:	**YES**	**NO**	**Urogynelogical:**	**YES**	**NO**
Heart attack			Currently pregnant		
Other heart problems			Kidney problems		
Stroke/CVA/TIA			Bladder leakage		
Aneurysm			Bladder frequency		
Pacemaker/Defibrillator			Pelvic Pain		
Blood clot/DVT			**Mental Health:**		
High blood pressure			Depression		
Musculoskeletal:	**YES**	**NO**	Anxiety		
Osteoporosis			Chemical dependency		
Osteoarthritis			**Other Medical:**		
Back pain			HIV/STD		
Chronic headaches/migraines			Diabetes		
Jaw pain			Cancer: _____		
Broken bones/fractures			Balance Problems/Falls		
Fibromyalgia			Dizziness		
Respiratory:	**YES**	**NO**	Skin Disorders		
Asthma			Thyroid Problems		
COPD			Hepatitis		
Tuberculosis			Lyme disease		
Emphysema			Rheumatoid arthritis		
Sleep apnea			**Allergies**		
Neurological:	**YES**	**NO**	Latex allergy?		
Seizures/Epilepsy			Other allergies? _____		
Multiple sclerosis			**Do you use tobacco?**		

Please list any other medical problems: _____

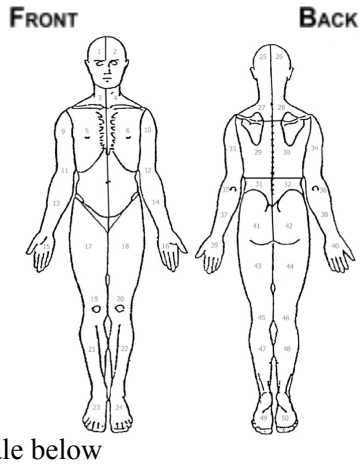
_____

Please list any previous surgeries or hospitalizations: _____

_____

Please indicate on the pictures to the right the location(s) of your symptoms. Use the following symbols:

■ = pain
/// =numbness
O=tingling



Please indicate your level of pain at its **WORST(W)** and **BEST(B)** on the scale below

0	1	2	3	4	5	6	7	8	9	10

(No pain) **(Excruciating pain)**

Are your symptoms: □ Getting better □ Staying the same □ Getting worse
Are you symptoms: □ Constant (24 hours/day)? or □ Intermittent?
What makes your symptoms better? _____
_____
What makes your symptoms worse? _____
_____
Have you had any diagnostic tests completed? □ X-Ray □ MRI □ CT scan □ EMG □ Other:_____
At what facility was the imaging or testing completed?: _____
For your current condition, which specialists are you currently seeing or have you seen in the past for this condition?
□ Family Doctor □ Physical Therapist □ Chiropractor □ Psychiatrist/Psychologist □ Orthopedist □ Other

Patient Demographics / Additional Questions

Height: _____ Weight: _____ □ Right handed □ Left handed
Has your weight changed significantly in the past year? YES NO
Would you like to lose weight? YES NO
Are you a member of a fitness club? YES NO
Are you currently exercising regularly? YES NO
If so, what type and how often? _____
Do you have access to any type of fitness equipment? What type? _____

Do you feel safe in your current living situation? YES NO

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO
Is this something for which you would like help? NO YES, BUT NOT TODAY YES

Do you have any conditions that affect your ability to communicate effectively with your therapist? (please explain)
_____
How do you effectively learn? □ Listening (discussion) □ Seeing (reading/ watching a video) □ Doing (practicing skill)

Physical Therapy Goals

What do you expect to accomplish with physical therapy? _____
_____

Current Work Information

Do you currently work outside of the home? YES NO Your current job title: _____
Do you have physician-prescribed work restrictions? YES NO Please describe: _____
_____
Do you have a case manager? NO If yes please list their name and phone #: _____