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			A**llergies**		
Neurological:	**YES**	**NO**	Latex allergy?		
Seizures/Epilepsy			Other allergies? _________________		
Multiple sclerosis			**Do you use tobacco?**		

Please list any other medical problems: ____

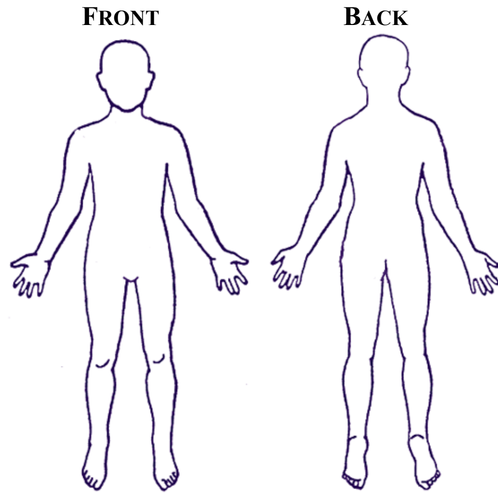
____

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 Current place of employment:____________
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 #: ______________