Name: _____DOB: _____ Date: _____

What is the reason for your visit? _____
When did the problem start? _____
How did the problem occur? _____
Please indicate which side of your body this problem exists: Right Left Both
Are you receiving other treatment for this condition? Yes No
If yes: what treatment, where, and by whom: _____
Have you ever had imaging? ____ Yes No
Type of Imaging: _____ Where Completed: _____
Have You had Surgery Recently? Yes No Date of Surgery: _____
Type of Surgery: _____
Have you Had any falls in the past month? Yes No How many falls have you had in the last 6 months? _____
Are you allergic to latex? Yes No

Medical History Have you or do you have any of the following (please circle all that apply)?

Alzheimer's Disease	History of Cancer	Asthma
Cardiovascular Disease	Huntington's	Chest Pains
Cauda Equina Syndrome	Immunosuppression	Depression
Cerebral Vascular Accident	Lupus	Multiple Sclerosis
Current Infection	Muscular Dystrophy	Vertigo
Diabetes Mellitus Type 1	Obesity	Vision Loss
Diabetes Mellitus Type 2	Osteoarthritis	Unexplained Weight Change
Fibromyalgia	Parkinson's	
Fracture or Suspected Fracture	Rheumatoid Arthritis	
High Blood Pressure	Traumatic Brain Injury	

Other: (please specify)_____
Are You Currently Pregnant? Yes No If yes, how many weeks along? _____

Surgical hx:
Surgery performed: _____Body Region: _____Date: _____
Surgery performed: _____Body Region: _____Date: _____

Medications
Type:_____Reason:_____Dosage:_____Frequency:_____
Type:_____Reason:_____Dosage:_____Frequency:_____
Type:_____Reason:_____Dosage:_____Frequency:_____

Have you had Physical Therapy in the past? Yes / No
If Yes, please indicate what you were seen for and when:_____

What are your current physical therapy goals? 1._____2._____

Please list 3 activities that you have the most difficulty performing. Please rate your ability level to complete this activity:
0% means you are completely unable to complete the activity 100% means you can complete the activity without difficulty.

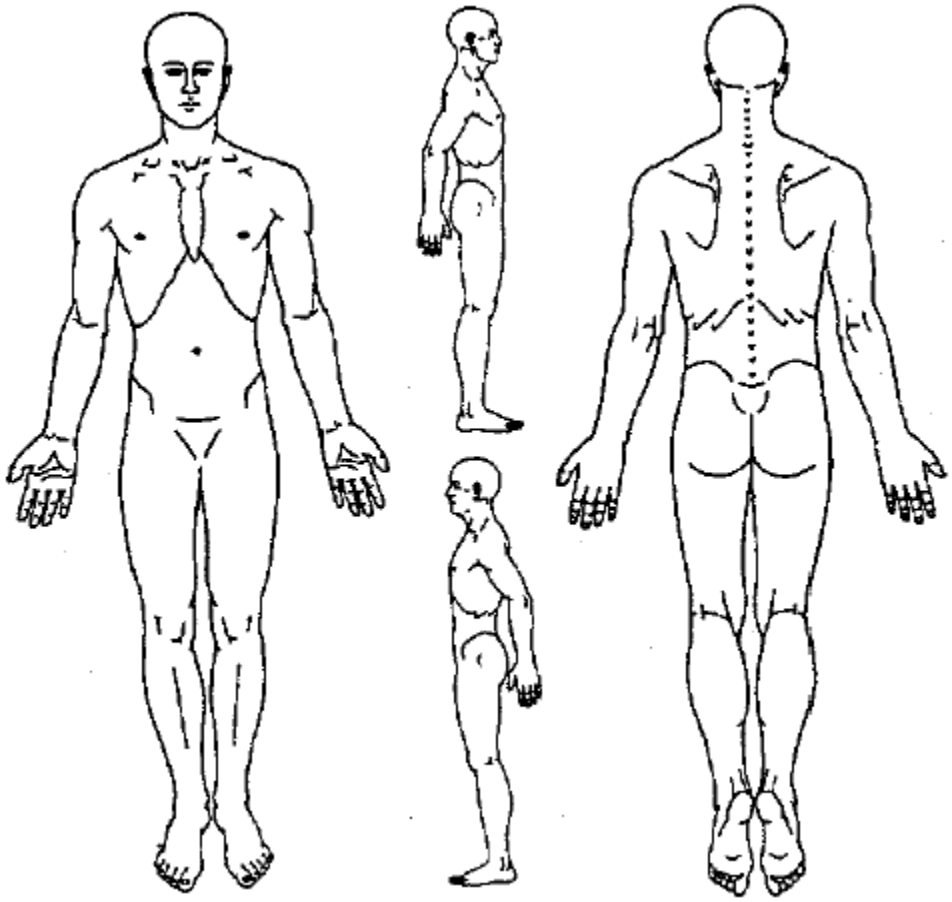
Activity 1: _____ Level: ___/100%

Activity 2: _____ Level: ___/100%

Activity 3: _____ Level: ___/100%

1. On the diagram, mark where you are experiencing pain right now. Use the letters below to indicate the type and location of your sensation.

A – Ache B – Burning N – Numbness P – Pins/Needles S – Stabbing O – Other



2. Rate the severity of pain by checking one box in the scale below.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

What percentage of your day do you have pain? (please circle):

0-25% **26-50%** **51-75%** **76-100%**

Is there anything else you would like your therapist to know?

_____
_____
_____
_____