



PHYSICAL THERAPY

Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Do You Exercise?  Yes  No If yes, how often: \_\_\_\_\_

Are you on work restriction from your doctor?  Yes  No Are you latex sensitive?  Yes  No

Do you smoke?  Yes  No Do you have a pacemaker?  Yes  No

FOR WOMEN: Are you pregnant or think you might be pregnant?  Yes  No

ALLERGIES: List any medication(s) you are allergic to: \_\_\_\_\_

Have you RECENTLY noted any of the following (check all that apply)?

- Checkboxes for symptoms: Fatigue, Numbness or tingling, Constipation, Fever/chills/sweats, Muscle weakness, Diarrhea, Nausea / vomiting, Dizziness / lightheadedness, Shortness of breath, Unexplained weight loss/gain, Heartburn / indigestion, Depression, Difficulty maintaining balance while walking, Difficulty Swallowing, Cough, Falls, Changes in bowel or bladder function, Headaches

Please list any medications you are currently taking including pills, injections and/or skin patches. (You may also provide us with a copy of your medication)

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Have you had recent surgery?  Yes  No Type of Surgery \_\_\_\_\_ Date: \_\_\_\_\_

Have you had home health care recently?  Yes  No If yes, date of discharge: \_\_\_\_\_

What date approximately did your present symptoms start? \_\_\_\_\_

What do you think caused your symptoms? \_\_\_\_\_

I should not do physical activities that might make my pain worse  Disagree  Unsure  Agree

Treatment received so far: (chiropractic, physical therapy, injections, surgery, etc.) \_\_\_\_\_

Please list special tests performed for this problem: (x-ray, MRI, labs, etc.) \_\_\_\_\_

What, if any, restrictions have been imposed by your physician? \_\_\_\_\_

Have you ever had this problem before?  Yes  No When \_\_\_\_\_ Treatment received \_\_\_\_\_

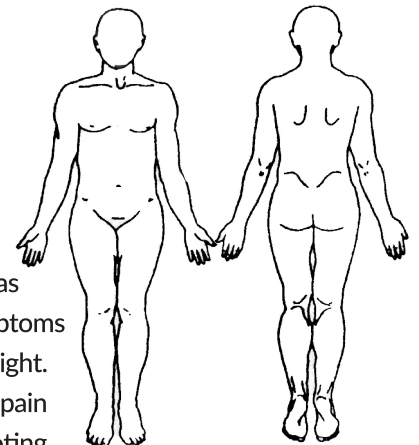
How long did it take for you to feel better? \_\_\_\_\_

- Do your symptoms:  Come and go  Are constant
 Are constant, but change with activity

- How are you currently able to sleep at night due to your symptoms?
 No problem sleeping  Difficulty falling asleep
Awakened by pain Sleep only with medication

- When are your symptoms worst?
 Morning  Afternoon  Evening  Night  After exercise

- When are your symptoms best?
 Morning  Afternoon  Evening  Night  After exercise



Body Chart: Please mark the areas where you feel symptoms on the chart to the right. Indicate the type of pain such as: Sharp, Shooting, Dull, Throbbing, Numbness / Tingling etc.