Your Full Name: _____

Please complete all of the following. Thank you.

What is the reason for your visit today?

Have you previously received treatment for this condition from:

☐ Physical Therapist ☐ Occupational Therapist ☐ Doctor ☐ Chiropractor ☐ Other: _____

Briefly describe the treatment you received: _____

_____

What is your main goal in coming to Physical Therapy? _____

_____

Do you have any other symptoms/pain that are related or unrelated to your condition? _____

Pain Assessment

Do you have pain now? ☐ Yes ☐ No
If you answered yes above, please continue with questions below.
If you answered no, skip the section below.

Pain intensity: On a 0-10 scale (0 being no pain, 5 = moderate pain, 10 = worst pain you can imagine), how would you rate your pain? Average Pain Currently: _____ At its worst _____ At its best: _____

On a 0-10 scale, at what level of pain are you able to function as you want? _____

Is your current pain: ☐ Constant ☐ Intermittent If intermittent, what percentage of the day do you have pain? _____
Location of pain: _____
Describe your pain (aching, burning, stabbing, etc.): _____
_____

Do you have any of the following symptoms: ☐ Numbness ☐ Tingling ☐ Pins ☐ Needles ☐ Limb falling asleep
If so, what locations of your body? _____

What causes your pain to increase? _____

What relieves your pain? _____

What time of day is your pain worse: ☐ Morning ☐ Midday ☐ Evening ☐ Night

What everyday activities are limited by your current pain (work, driving, laundry)? _____

Personal Information / Social History

Hand dominance: ☐ Right ☐ Left

Work Status: ☐ N/A ☐ Full Duty ☐ Retired ☐ Off because of current injury: How long? _____

☐ Work with the following restrictions: _____
Duties/Physical Demands at Work: _____

Recreation Activities / Sports include: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how many times per week? _____

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs a day ___ ? For how many years? _____

If not, were you a former smoker? ☐ Yes ☐ No When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No Amount per week: _____ drinks per (check one) ☐ day ☐ week ☐ month

Overall, would you describe your sleep as: ☐ Good ☐ Fair ☐ Poor How many times per night do you wake? _____

Is the reason you wake up related to your current problem: ☐ Yes ☐ No

Do you currently take medication to sleep? ☐ Yes ☐ No

Your Full Name: _____

Diagnostic Testing Please list any tests you have had for any condition in the last 3 months (x-ray, MRI, EMG, CT scan, etc.)

Current Medications Please list all medications you are now taking, including over the counter and nutritional supplements. If you have a list of medications, you may give it to us and omit this section.			

Past Medical History Please check current and past medical problems that you have been treated for.			
☐ Cancer	☐ Osteoarthritis	☐ Loss of Bowel Control	☐ Bleeding Problems
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Loss of Bladder Control	☐ Intestinal Disorders
☐ Heart Disease	☐ Headaches	☐ Epilepsy or Seizures	☐ Infections
☐ High Blood Pressure	☐ Osteoporosis	☐ Asthma	☐ Circulatory Problems
☐ CVA-Stroke	☐ Gout	☐ COPD or Emphysema	☐ Liver Problems / Hepatitis
☐ Pacemaker	☐ Metal Implants	☐ Chronic Bronchitis	☐ Thyroid Problems
☐ Gallbladder Problems	☐ Kidney Disease / Stones	☐ Currently Pregnant	☐ Multiple Sclerosis
☐ Depression / Anxiety	☐ Tuberculosis	☐ Parkinson's	☐ Fibromyalgia
☐ Other:			

Past Surgical History Please list your previous surgeries and the year you had the surgery.	
Surgery	**Year**