Patient Name: _____ Date: _____

Occupation: _____ Age: _____

Diagnosis: _____

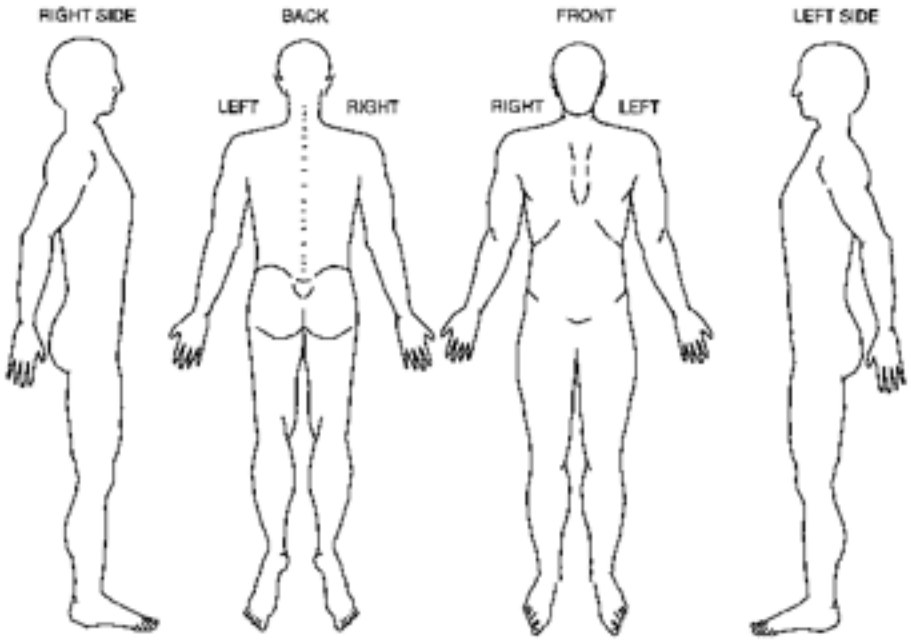
When did your symptoms begin: _____

How did your symptoms begin: _____

Using the diagrams, mark the location of your symptoms:

Rate your symptoms:
0 = no pain
10 = worst pain ever

Current: _____
At best: _____
At worst: _____



Circle all that apply:

Dull
Sharp
Achy
Heaviness
Shooting
Burning
Numbness
Tingling
Unpredictable
Other: _____

What percentage of the time do you have symptoms?
_____100-75%(constant) ____ 75-50%(intermittent) ____ 50-25%(occasional) ____ 0-25%(infrequent)

What makes your symptoms worse? (circle all that apply)

Sitting	Standing	Bending	Walking	Running	Squatting	Driving
Up stairs	Down stairs	Lying down	Lifting	Overhead	Pushing	Pulling
In the AM	At night	As the day progresses		Other: _____		

What makes your symptoms better? (circle all that apply)

Sitting	Standing	Bending	Walking	Running	Squatting	Driving
Up stairs	Down stairs	Lying down	Lifting	Overhead	Pushing	Pulling
In the AM	At night	As the day progresses		Other: _____		

Have you had this problem before? yes no If yes, what treatment was helpful?_____

List results of x-rays, MRI, etc _____

What is your current level of activity/exercise?_____

_____

Medical History: Please circle all that apply and note current vs past issue

Allergies	Headaches	Pain at night
Anemia	Heart Disease	Pain with Cough/Sneeze
Asthma	Heart Palpations	Polio
Autoimmune disease	Hernia	Rheumatoid Arthritis
Balance problems	High Blood Pressure	Shortness of breath
Bowel/bladder change	Low Blood Pressure	Skin Abnormalities
Cancer	Kidney Problems	Smoking History
Chest pain	Major illness/Accident	Seizures
Concussion	Migraines	Stroke
Diabetes I or II	Multiple Sclerosis	Unexpected weight change
Difficulty sleeping	Numbness/tingling	Urine Leakage
Dizziness	Osteoarthritis	Vision problems
Depression	Osteoporosis	Weakness in arms or legs
Fibromyalgia	Pacemaker	Other_____

Previous Surgeries or Hospitalizations:

1._____Date:_____

2._____Date:_____

Previous Injuries/Orthopedic problems:

1._____

2._____

Current Medications and Supplements:

Name	Dose	Frequency	Route	Reason taking:

Please identify up to three important activities that you are unable to do or are having difficulty with as a result of your symptoms. Rate each activity: 0 = unable to perform, 10 = no problem

1._____Rating_____

2._____Rating_____

3._____Rating_____

Please list your goals for physical therapy:

1._____

2._____

3._____

List any other information or comments that might be helpful: