studiobrava
PHYSICAL THERAPY

NAME_____ **BODY PART**_____ **DATE**_____

Occupation_____ Interests/Hobbies_____

Are you currently receiving ANY form of Home Heath Care? **YES/NO** For?_____

Next Scheduled Dr. appointment (s) Date_____ Physician_____

Questions About Your Condition:

When did your condition start: Give specific date of injury or onset of pain? _____

Did you have surgery **YES/NO** When?_____ What surgery was done?_____

Did you have any of the following tests? **YES/NO** ___**XRAY** ___**MRI** ___**CT Scan** ___**EMG** ___ **OTHER**_____

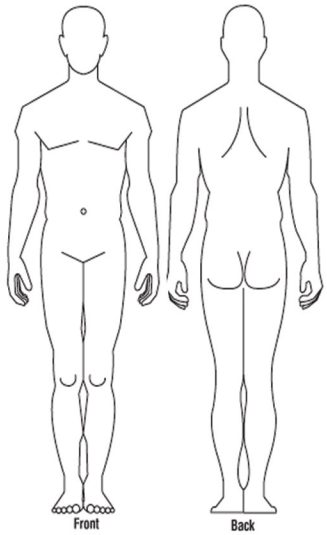
Have you been treated here or by another physical therapist before? YES/NO Same Condition? YES/NO

Where?_____ When?_____ Who referred you?_____

Are you currently taking any medications? **YES/NO** Please list _____

(use back of page if you need more space.)

Do you have PAIN? If so DRAW on the BODY CHART where your pain is located>>>>>>>>>



What does your pain feel like? (check all that apply)

___**SHARP** ___**BURNING** ___**ACHING** ___**TINGLING** ___**NUMBNESS** ___**OTHER**_____

Does pain radiate to arms to legs? YES/NO Does the pain keep you up at night? **YES/NO**

Rate your PAIN on a 0 to 10 scale: 0 1 2 3 4 5 6 7 8 9 10 (circle one)

(0=none, 10=severe)

What makes your pain worse? 0 1 2 3 4 5 6 7 8 9 10 (circle one)

___**LYING DOWN** ___**SITTING** ___**STANDING** ___**WALKING** ___**OTHER**_____

What eases your pain? 0 1 2 3 4 5 6 7 8 9 10 (circle one)

___**LYING DOWN** ___**SITTING** ___**STANDING** ___**WALKING** ___**OTHER**_____

Activity Level: ___**LOW** ___**MEDIUM** ___**HIGH** Recent weight loss or gain? **YES/NO** How much?_____

Any other conditions we should be aware of?_____

Are you sensitive to Heat/Ice **YES/NO** Are you Pregnant? **YES/NO** Were you in a Motor Vehicle Accident? **YES/NO**

Do you now or have had any of the following? (check what applies)

___Heart Disease	___Diabetes	___Alllergies	___High Blood Pressure
___Heart Attack	___Pacemaker	___Kidney Problems	___Headaches
___Cancer	___Seizures	___Hernia (any)	___Nervous Disorders
___Stroke	___Dizziness	___Kidney Problems	___Asthma/Shortness of Breath
___Previous Surgery	___Metal Implants	___Infectious Disease	___Thyroid Problems

If yes to any of the above please give details and approximate dates:_____

_____

All statements above are true to the best of my knowledge _____

PATIENT SIGNATURE AND DATE