



Name _____ Date of Birth _____ Date _____

Height: _____ Weight: _____ MD Follow up Date: _____

What is your reason for coming to therapy today? _____

Date of injury or when problem began? _____

How did your problem start? Lifting Twisting Falling Motor vehicle accident Bending

Describe: _____

What type of hobbies / activities / exercise did you regularly perform (prior to injury) and how often? _____

Have you had any diagnostic tests (x-ray, MRI, CT scan, etc)? _____

Please mark the location of your pain on the chart below.

Pain at **LOWEST**: Rate your lowest pain level in past week
0 = No pain 10 = Worst pain imaginable

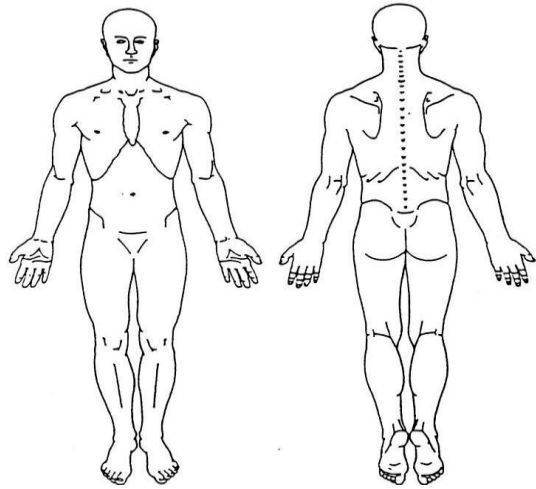
0 1 2 3 4 5 6 7 8 9 10

Pain at **WORST**: Rate your highest pain level in past week.
0 = No pain 10 = Worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Pain **CURRENTLY**: Rate your level of pain at this time.
0 = No pain 10 = Worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10



What makes your pain better? _____ What makes your pain worse? _____

Please **CIRCLE** the areas where you have seen a **DECLINE** in your abilities with your most recent condition.

- | | | | | |
|----------|-----------|----------------------|-------------------------|---------------------|
| Working | Lifting | Kneeling | Sleeping / Resting | Dressing / Grooming |
| Sitting | Carrying | Gripping | Getting in / out of bed | Balance |
| Standing | Bending | Turning head / trunk | Lying Down | Exercise Routine |
| Walking | Squatting | Driving | Rising from sitting | Other _____ |

Does your past medical history include any of the following? (**Circle all that apply**)

- | | | | |
|----------------------|---------------------------|--------------------|----------------------|
| Cardiac Problems | High Blood Pressure | Pacemaker | Cancer |
| Fibromyalgia | Diabetes | Osteoarthritis | Rheumatoid Arthritis |
| Seizures | Depression | Asthma | Orthopedic Problems |
| GI Problems | Kidney Problems | Multiple Sclerosis | Muscular Dystrophy |
| Parkinson's Disease | Drug / Alcohol Dependency | Infectious Disease | Autoimmune Disease |
| Stroke / TIA | Open Wound | Brain Injury | Concussion |
| Spinal Cord Injury | COPD | Lung Disease | Pregnancy |
| Urinary Incontinence | Bowel Incontinence | Pelvic Pain | |

BALANCE

- Have you had two or more falls within the past year? Yes / No
- Have you had one fall resulting in injury within the past year? Yes / No

Please list any major surgeries with dates _____

List allergies (medication, latex, etc) _____

List all medications you are currently taking: See List attached None

What are your goals for therapy? _____

PATIENT SIGNATURE _____