NAME _____ DATE_____

Date of Birth _____

Reason for Visit Today Describe the problem(s) for which we are seeing you today? _____
_____

When did the problem begin? _____

How did the problem begin? Was it sudden? or Gradual? Please Explain:

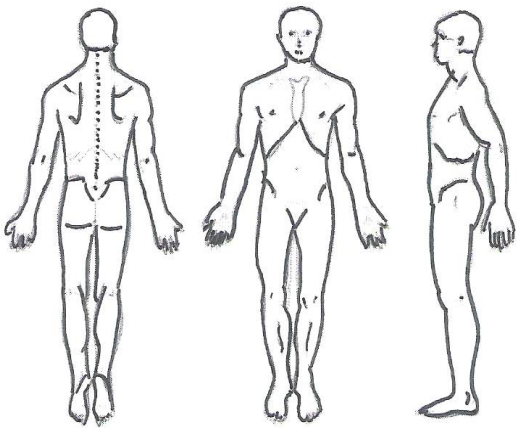
_____

Have you ever had this problem before? YES NO

WHEN? _____

What did you do for the problem? _____

Was the problem/pain resolved? _____



Back **Front** **R or L Side**

RATE your Pain on scale of 0-10 _____
Pain Drawing Please detail your pain on the diagram to the right >>>
You may use descriptive words to help explain your pain.

What makes your pain worse? (Please circle any/all that apply)

Lying Down Sitting Standing Walking Driving Running Working
Time of Day Too Much Activity Bending Reaching Lifting Squatting
Kneeling Too Little Activity Other (Specify): _____

What makes your pain decrease? (Please circle any/all that apply)

Lying Down Sitting Standing Walking Driving Running Working
Time of Day Too Much Activity Bending Reaching Lifting Squatting
Kneeling Too Little Activity Other (Specify):_____

Sleep Patterns How many hours do you sleep at night? _____ How many hours/day do you spend in bed? _____
Does pain awaken you from a sound sleep? Yes No

Date of last Physical Examination _____ By Whom_____

Please check (√) any of the following whose care you are under for this, or any other reason

_____ Medical Doctor (MD) _____ Physical Therapist Other _____
_____ Osteopath (DO) _____ Dentist
_____ Psychiatrist/Psychologist _____ Chiropractor

If you have seen any of the above practitioners during the past 3 months, please describe the reason

_____

Are you pregnant? YES NO Is there a chance you might be? YES NO

What was your last vaccination?_____ Did you become ill? Yes No
When did you last travel out of the country? _____ Did this require inoculation? Yes No

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

ARE YOU LATEX SENSITIVE? YES NO **List any other allergies** _____

Please placer a √ in front of any Condition(s) YOU Have

Alcoholism	High Cholesterol	Gout	Lyme	Rheumatoid Arth.
Asthma	COPD	Heart Disease*	Lymphatic	Seizure Disorder*
Autoimmune*	Diabetes	Hypertension (HBP)	Muscle Disease*	Thyroid Disorder*
Cancer*	Fibromyalgia	Liver	MRSA	Varicose Veins

Other/Not Listed_____

*** Please provide more information** _____

List Prescribed medications you are taking: INCLUDE pills, injections, skin patches, birth control

Name	Dosage	How long have you been taking it?

Please check (√) any OTC medications/Supplements you have taken in the last week.

_____ Aspirin _____ Laxatives _____ Other _____

_____ Tylenol _____ Antacid _____ Other _____

_____ Advil, Motrin, _____ Decongestant _____ Other _____

_____ Ibuprofen, Aleve _____ Antihistamine _____ Other _____

Please list any surgeries, medical tests (MRI, X-ray etc), and/or hospitalizations, w/ the approximate date and reason.

1. _____ _____ 5. _____ _____
2. _____ _____ 6. _____ _____
3. _____ _____ 7. _____ _____
4. _____ _____ 8. _____ _____

Please describe any significant injuries, for which you have been treated, including fractures, dislocations, sprains, and the approximate date of injury.

1. _____ _____ 3. _____ _____
2. _____ _____ 4. _____ _____

Do you have any limitations because of prior injuries or surgeries? YES NO Describe _____

_____

OTHER INFO

Health Habits:

____ **Tobacco**: How many years? _____ Cigarettes #/day _____ Cigars #/day _____ Pipe _____ Chewing _____

____ **Alcohol**: Wine or beer #glasses/day or week _____Liquor # ounces/day or week _____

____ **Caffeine**: Coffee: #6 oz cups/day _____ Tea: #6 oz cups/day _____ · Soda w/caffeine: # cans/day _____

Nutrition and Diet: Please Circle

Vegetarian Vegan High Protein Salt Restriction Low Fat Diet Carbohydrate Restriction

The Zone Diet Atkins Diet Other: _____

How often do you Exercise: (Check all that apply)

____ 5-7 days per week _____3-4 days per week ____ 1-2 days per week _____ Infrequent ____ Never

_____ 45 minutes or longer per workout _____ 30-45 minutes per workout _____ Less than 30 minutes/workout

____ Walk _____ Run _____ Cycle _____ Swim ____ Yoga ____ Other:_____

Current Assistive Devices: _____ Cane _____ Walker _____ Wheelchair _____ Prosthetics
_____ Pacemaker _____Glasses/Contacts _____ Hearing Aids _____ Dentures
_____ Shunt _____Insulin Pump _____Baclofen Pump _____Other _____

Present Home Environment: _____Private home _____Assisted Living Facility

_____ One-level living (no stairs) _____Stairs, no railing _____ Stairs w/ railing (s) which side _____

_____ Ramps _____Elevator _____Bathroom Modifications _____

Do you live alone? Yes NO If not, with whom do you live? _____

YOUR GOALS OF PHYSICAL THERAPY This section will help us design your plan of care. Goals may be revised as needed. Please fill in the following so we will understand your goals.

Please list YOUR main complaints/challenges you have in order of their importance:

1.	4.
2.	5.
3.	6.

PATIENT CENTERED GOALS What do you hope to achieve from PT?

1.
2.
3.
4.

_____ _____

Patient Signature Date Therapist Signature Date