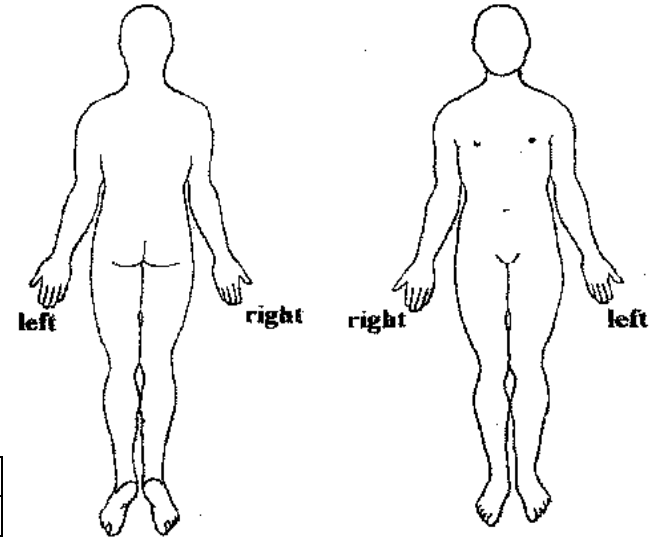


Name:	Date of Birth:	Referring Provider:
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Reason for Therapy:	Occupation:
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Date the condition began: _____
 Is this work-related injury? (Circle One): Yes No
 Prior physical therapy? (Circle One): Yes No
 Date of next MD appointment for this condition: _____

Please indicate the location of your symptoms on diagram



Current Symptoms

Please indicate your pain intensity at its worst: (Circle One)

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Please indicate your pain intensity at its worst: (Circle One)

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Please check the description of your pain (any that apply):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Constant (>75%) | <input type="checkbox"/> Frequent (50-75%) | <input type="checkbox"/> Occasional (25-50%) | <input type="checkbox"/> Intermittent (< 25%) |

What increases the pain: _____
 What decreases the pain: _____

Please list any imaging tests performed and the results below:

Past Medical History (Please check all that are applicable):

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> DVT | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Closed Head Injury | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Frequent UTI | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> GERD | <input type="checkbox"/> IBS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> COPD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine(s) | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Degenerative Disc Dx | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> MRSA | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> MI/Heart Attack | <input type="checkbox"/> Urinary Incontinence |

Cancer Location(s) and Date(s):	
Family/Other Medical Hx:	

Social History

Do you smoke or use smokeless tobacco products?

No, I do not use these products Yes, I smoke _____ packs per day Yes, I use smokeless products _____ times per day

Do you drink alcoholic beverages?

No Yes, If so: How many drinks per day? _____ How many drinks per week? _____

Medications

Not currently taking any medications Please see attached medication list OR List meds on back page

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Signature: (Patient/Authorized Representative: (X) _____ Date: _____

(Office Use Only) **Therapist Initials:** _____

