Please write so legibly a half-blind person could easily read this!

Name:

Address:
(include zip)

DOB:

Cell Phone:

e-mail:

Doctor ordering Physical Therapy:

Primary Care Physician:

Emergency Contact Name:
and Cell Number:

Occupation/activities that comprise your average day:

Sports or exercises you engage in:

Are you on any restrictions from your doctor? ☐ **Yes** ☐ **No**

Are you latex sensitive? ☐ **Yes** ☐ **No**

Do you smoke? ☐ **Yes** ☐ **No** **Do you have a pacemaker?** ☐ **Yes** ☐ **No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ **Yes** ☐ **No**

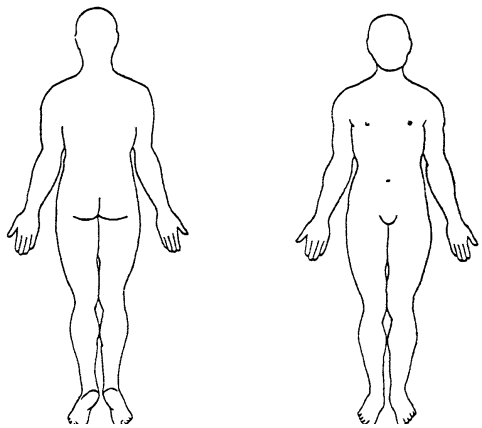
Have you RECENTLY noted any of the following (check all that apply)?

☐ fatigue	☐ numbness or tingling	☐ constipation
☐ fever/chills/sweats	☐ muscle weakness	☐ diarrhea
☐ nausea/vomiting	☐ dizziness/lightheadedness	☐ shortness of breath
☐ weight loss/gain	☐ heartburn/indigestion	☐ fainting
☐ difficulty maintaining balance while walking	☐ difficulty swallowing	☐ coughing
☐ falls	☐ changes in bowel or bladder function	☐ headaches

Body Chart:

Please mark your current symptoms on the chart:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



When (roughly) did your present symptoms start?

What do you think caused your symptoms?

My symptoms are currently: ☐ **Getting Better** ☐ **Getting Worse** ☐ **Staying about the same**

Treatment received so far for this problem (e.g., chiropractic, injections, etc):

Has the treatment you received so far made you feel better?

Please list special tests performed for this problem and results (x-ray, MRI, labs, etc):

Have you ever had this problem before: ☐ **Yes** ☐ **No** **If Yes, when**?:

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

---

Aggravating Factors: Identify up to 3 positions or activities that make your symptoms worse & rate the level of pain associated with them using the 0-10 scale, with 0 being, "no pain," and 10 being the "worst pain imaginable."

Aggravating Position or Activity:	Highest Pain Level:
1.	
2.	
3.	

Easing Factors: Identify up to 3 positions or activities that make your symptoms better:

Position or Activity Which Lessens Symptoms	Lowest Pain Level
1.	
2.	
3.	

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ cancer
- ☐ heart problems
- ☐ chest pain/angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke
- ☐ anemia
- ☐ bone or joint infection
- ☐ chemical dependency (i.e., alcoholism)
- ☐ depression
- ☐ lung problems
- ☐ tuberculosis
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder/urinary tract infection
- ☐ kidney problem/infection
- ☐ sexually transmitted disease/HIV
- ☐ pelvic inflammatory disease
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ eye problem/infection
- ☐ ulcers
- ☐ liver problems
- ☐ hepatitis
- ☐ pneumonia

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

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

During the past month have you been feeling down, depressed or hopeless? ☐ **Yes** ☐ **No**

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ **Yes** ☐ **No**

Is this something with which you would like help? ☐ **Yes** ☐ **Yes, but not now** ☐ **No**

Surgeries or other conditions for which you have been hospitalized, including dates:

What are your expectations of me?:

✪ **Please come with clothes you can move in and which allow for complete examination of all relevant areas (e.g., shorts, sports bra).**