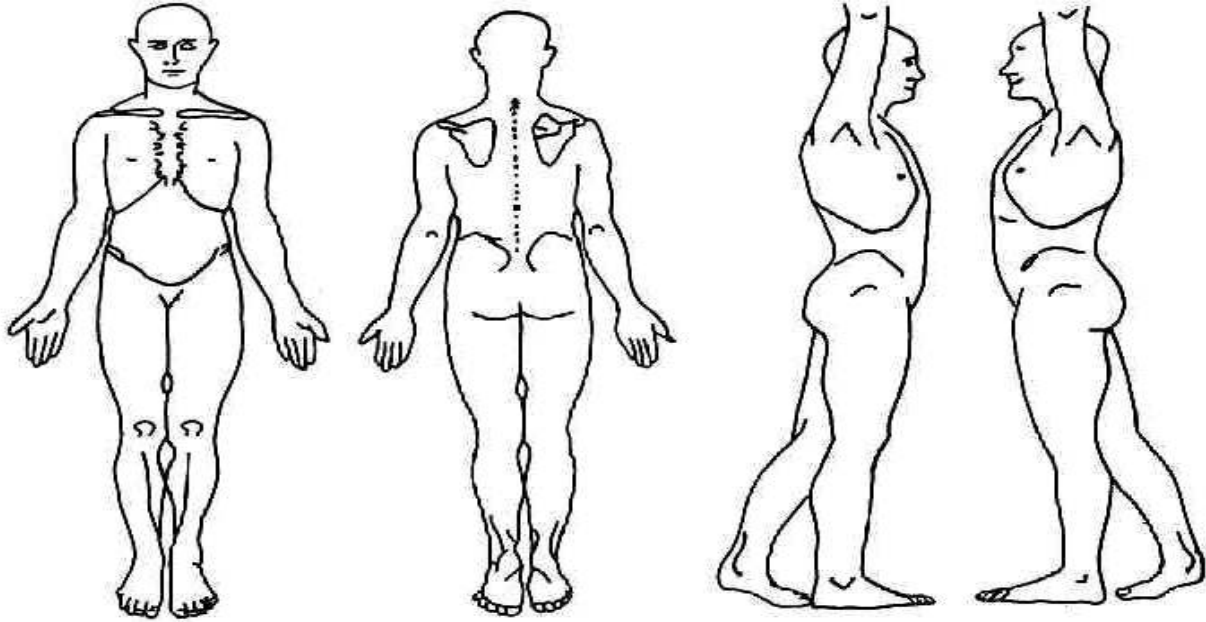


Name: _____

Date: _____

1. What problem are you here for today? _____
2. Date of Injury: _____
3. Describe how / when your problem occurred? _____

4. Please mark on the body chart below your area of discomfort.



5. Mark on the scale below your current level of discomfort.
0 -----10
0 = no pain 10 = pain is so intense you need to go to the ER

6. Check the box that best describes how your discomfort changes during the day.

	Morning	Afternoon	Evening
Better			
Worse			

7. Does your pain wake you at night? YES NO

8. Which activities increase your symptoms?

Sitting Walking Kneeling Twisting Standing Reaching
Lifting Bending Squatting Stairs Rising from a chair Other: _____

9. What eases your symptoms?

Heat Ice Medication Rest Change in Position Other _____

10. Is your condition overall? IMPROVING GETTING WORSE STAYING THE SAME
11. Have you had a similar problem previously? YES NO
 If YES, when _____
12. Have you had any treatment for this problem in the past? YES NO
 If YES, Please explain: _____
13. Are you able to continue working? YES NO
 If NO, when did you last work? _____
14. Are the physical demands of your job? LIGHT MODERATE HEAVY
 Specifics _____
15. Are you able to continue your recreational or sporting activities? YES NO
 Specifics _____
- What are your goals and expectations for Physical Therapy? _____
-

MEDICAL INFORMATION

1. Please circle if you have had any of the following tests for this problem:
- | | | | |
|------------------------|----------|-------------|----------------|
| x-rays | CAT scan | Bone scan | Electromyogram |
| Nerve conduction study | MRI | Other _____ | |
- Known Results _____
2. Are you currently taking any medications? YES NO
 Name, dosage _____
3. Please circle if you have experienced any of the following with your current problem:
- | | | | | |
|----------------------------------|-----------------------------|------------------------|---------------------------------------|-----------------|
| Locking | Dislocating | Giving away | Dropping items | Unconsciousness |
| Nausea | Loss of balance | Lip numbness | Numbness around the groin or buttocks | |
| Loss of bowel or bladder control | Dizziness or blurred vision | Pain with cough/sneeze | | |
4. How would you describe your overall health? POOR FAIR GOOD EXCELLENT
5. Please circle any of the following that are in your past or present medical history:
- | | | | | |
|-------------------------------|---------------------|-------------|----------------|-----------------|
| Cancer | Lung problems | Arthritis | Broken bones | Sprains/strains |
| Concussion | Seizures | Blood clots | Allergies | Surgeries |
| Diabetes | Heart disorder | Pacemaker | Nerve disorder | Asthma |
| Unusual or frequent headaches | High blood pressure | Other _____ | | |
6. Have you had any long term use of Prednisone, Cortisone, Steroids or Inhalants? YES NO
 If YES, please specify _____