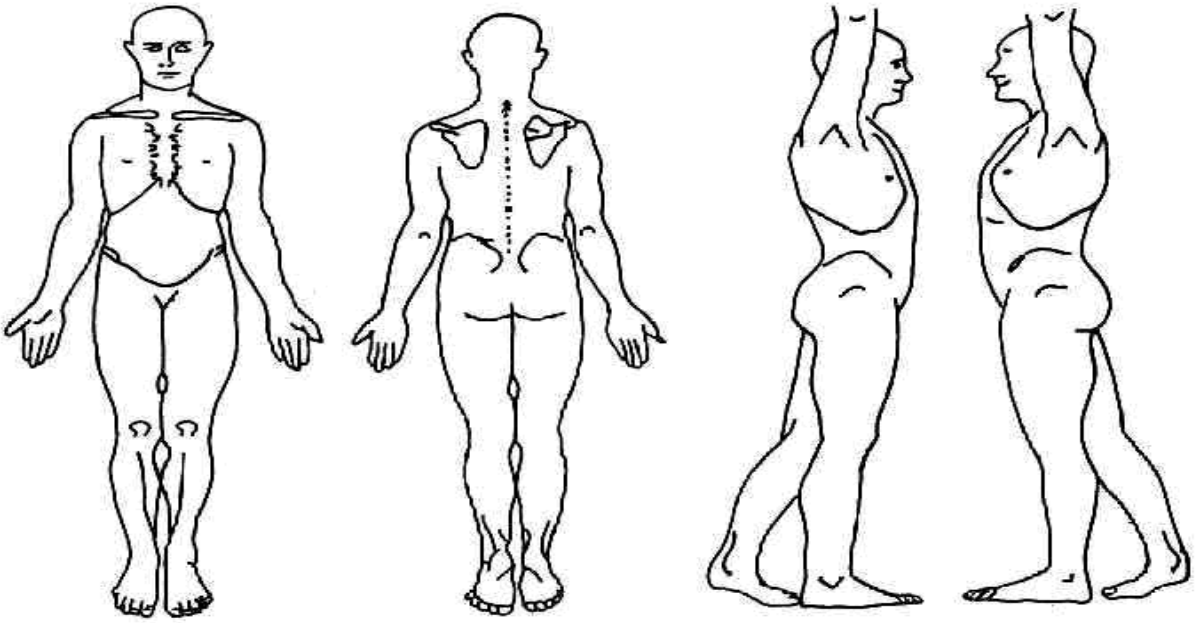
PATIENT HEALTH INFORMATION

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 _____

PATIENT HEALTH INFORMATION

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 Electromyelogram

Nerve conduction study MRI Other _____

Known Results _____

2. Are you currently taking any medications? YES NO

Name of medicine	Dosage	Reason for taking medicine

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 _____