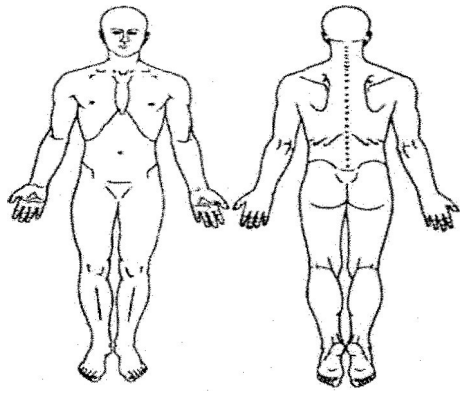
GENERAL HEALTH INFORMATION

Patient Name: _____Date:_____ Age:_____ Height: _____ Weight: _____
Diagnosis or Problem Area: _____ When did your pain begin? _____
Describe the "incident" above or how the injury occurred: _____
_____

Pain Diagram: Please shade in or circle the area to be treated



Is the pain getting: □Better □Worse □No Change
Is the pain: □Constant □Intermittent □Variable

Have you had any of the following test for this injury?

- ☐ Bone Scan
- ☐ MRI
- ☐ X-Ray
- ☐ EMG/Nerve Conduction Test
- ☐ CT Scan
- ☐ Other:

Previous surgeries:_____
_____
_____
_____

Medications:_____
_____
_____
_____

Rate your current pain on a scale of 1-10 (1 being no pain and 10 unbearable pain): 1 2 3 4 5 6 7 8 9 10

What is your pain at best? _____Worst?_____ Pain at rest? _____

What activities aggravate your injury/problem area? _____

What activities relieve your injury/problem area? _____

Is there any other information that you believe would assist the therapist in your care? _____
_____

Are you currently or have you ever experienced the following? Check all that apply:

☐ Chest Pain	☐ Respiratory Disease	☐ Imbalance/Frequent Falls	☐ Visual/ Hearing problems
☐ Heart Attack	☐ Difficulty breathing/shortness of breath	☐ Cancer	☐ Osteoarthritis
☐ High Blood Pressure	☐ Head Injury	☐ Severe Night Pain	☐ Rheumatoid Arthritis
☐ Low Blood Pressure	☐ Stroke	☐ Night Sweats	☐ Skin Rash/ Disease
☐ High Cholesterol	☐ Seizures	☐ Osteoporosis	☐ HIV/AIDS
☐ Poor Circulation	☐ Blackouts	☐ Osteopenia	☐ Hepatitis
☐ Bleed/Bruising Problem	☐ Thyroid	☐ Diabetes	☐ Smoking
☐ Blood Clots	☐ Dizziness	☐ Numbness to hands or feet	☐ Bowel/ Bladder Problems

If female, are you pregnant? Yes No Have you ever been pregnant? Yes No

Have you been to physical therapy in the last year? Yes No If so, where? _____

How did you hear about us? _____