Patient Name: _____DOB:_____ Age: _____

Primary Physician: _____ Referring Physician: _____ Return to Doctor Date: _____

Current Condition:

Problem/diagnosis: _____ Side of injury/pain: R L Date of injury/notice of pain:_____

Briefly describe your pain: _____

_____

_____

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain Imaginable

Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain Imaginable

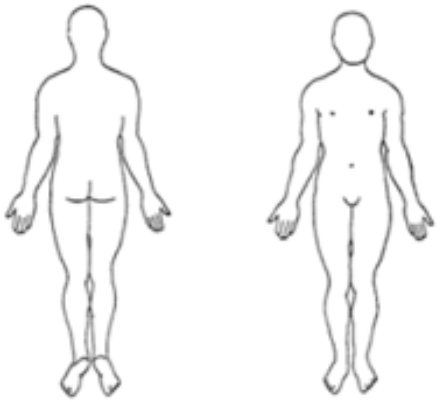
Pain at WORST: Rate your highest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:



Does this pain limit you normal activities? Y N If yes, which? _____

_____

What activities/movements increase your pain: _____

_____

What activities/movements decrease your pain: _____

_____

Have you had diagnostic tests for this condition? Y N If yes, when and where:_____

Circle Tests: X-Rays MRI Bone Scan CT Scan Nerve Tests Other: _____

Have you had any recent or past falls? Y N Date of last fall: _____ Number of falls in last year: _____

Cause of fall: _____

_____

Have you had previous Physical Therapy, Chiropractic care, or in home health care? Y N Number of Visits: _____

Are you still receiving care? Y N Name of facility: _____ Date of Discharge: _____

Past Medical History (Mark any/all that apply)

☐ Arthritis Type:_____	☐ Cancer Type:_____	☐ Coronary Artery Disease/ Heart Disease	☐ Hypothyroid/ Hyperthyroid
☐ Angina(Chest Pain)	☐ Fractures	☐ Poor Circulation/Raynaud's	☐ Stroke
☐ Asthma	☐ Kidney/Liver problems	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Blindness	☐ Hearing Problems	☐ Migraine Headaches	☐ Traumatic Injury
☐ Blood Clot	☐ High Cholesterol	☐ Major Spinal Injury	☐ Infectious Disease: MRSA/ VRE/ CDIF/ Staph Infection
☐ Carpel Tunnel Syndrome	☐ Hepatitis	☐ Osteoporosis	
☐ Depression/Anxiety	☐ High Blood Pressure	☐ Pacemaker/ Defibrillator	
☐ Diabetes	☐ Hypoglycemia	☐ Parkinson's Disease	☐ Other:
☐ Epilepsy	☐ Incontinence	☐ Polio	
☐ Fibromyalgia	☐ Lung Disease	☐ Seizures	

List Current Medications (prescription, over the counter, or supplements):

_____

_____

_____

List All Surgeries:

_____

_____

_____

List All Allergies:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent/Guardian (If minor) Signature: _____Date: _____