

PATIENT NAME: \_\_\_\_\_ Acct#: \_\_\_\_\_

**Please check if you have been diagnosed with any of the following conditions:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Diabetes(I/II)                                       | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> Stroke (TIA or CVA)  | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Metal Implants  |
| <input type="checkbox"/> Back Pain  | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Stomach ulcers  |
| <input type="checkbox"/> Broken bones   | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Depression          | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Infectious Diseases (HIV, Hepatitis, TB, etc.) _____ |   |  |  |
| <input type="checkbox"/> Other: _____   |   |  |  |

**Surgical History:** \_\_\_\_\_

**Have you recently noted? Check all that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Nausea/Vomiting     | <input type="checkbox"/> Dizziness spells    | <input type="checkbox"/> Pain at night              | <input type="checkbox"/> Currently pregnant       |
| <input type="checkbox"/> Unusual weakness    | <input type="checkbox"/> Visual problems     | <input type="checkbox"/> Heart Palpitations         | <input type="checkbox"/> Hearing problems         |
| <input type="checkbox"/> Bleeding            | <input type="checkbox"/> Difficulty walking  | <input type="checkbox"/> Joint pain or swelling     | <input type="checkbox"/> Fever/chills/sweats      |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Incontinence               | <input type="checkbox"/> Productive/Chronic Cough |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Unexplained weight changes | <input type="checkbox"/> Fatigue or myalgia       |

**Have you recently traveled out of the country?**  Yes  No

**Have you had direct prolonged contact with someone with confirmed case of coronavirus?**  Yes  No

**How many times have you fallen in the past 12 months?** \_\_\_\_\_ **Did it result in an injury?**  Yes  No

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

**Please list all, both prescribed and over the counter medications you are currently taking, include name, dosage, frequency, route taken:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sex:**  Male  Female **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Are you:**  Right handed  Left handed

**Do you have any allergies?**  Yes  No If yes, please list: \_\_\_\_\_

**With whom do you live:**

Alone  Spouse only  Spouse and others  Child  Other \_\_\_\_\_

**Where do you live:**

Private home  Apartment/rented room  Assisted living/group home  Hospice  Other \_\_\_\_\_

**Does your home have:**

Stairs, no railing  Stairs, railing  Ramps  Uneven terrain

**Please explain:** \_\_\_\_\_

**Employment/Work (Job/School/Play):**

Working:  Full time  Part time  Retired  Unemployed  Occupation: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

General Health Status, Please rate your health;  Excellent  Good  Fair  Poor

Date of onset of current symptoms/injury: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Describe the problem(s) for which you seek therapy: \_\_\_\_\_  
\_\_\_\_\_

Explain how problem(s) occurred: \_\_\_\_\_  
\_\_\_\_\_

How are you taking care of the problem(s) now? \_\_\_\_\_

What makes the problem(s) better? \_\_\_\_\_

What makes the problem(s) worse? \_\_\_\_\_

What functions could you perform before, that now you are unable to do? \_\_\_\_\_  
\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Have you ever had the problem(s) before? \_\_\_\_\_

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc. \_\_\_\_\_

Have you received X-rays, MRI, CT scan, Bone Scan, etc. for this problem? If so, what were the results  
\_\_\_\_\_

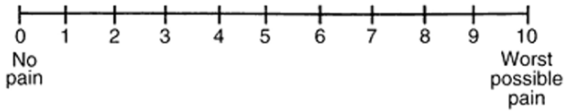
Are you aware of any physical reason why you should not receive treatment?  Yes  No

If yes, please tell us what it is: \_\_\_\_\_

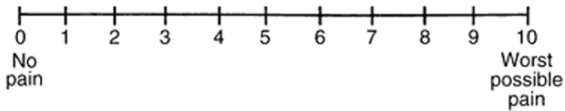
**Pain Rating:**

If you have pain, what is your pain level? Circle

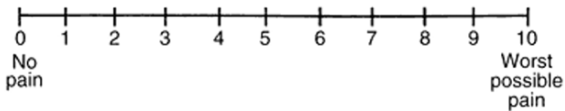
**CURRENT** Pain



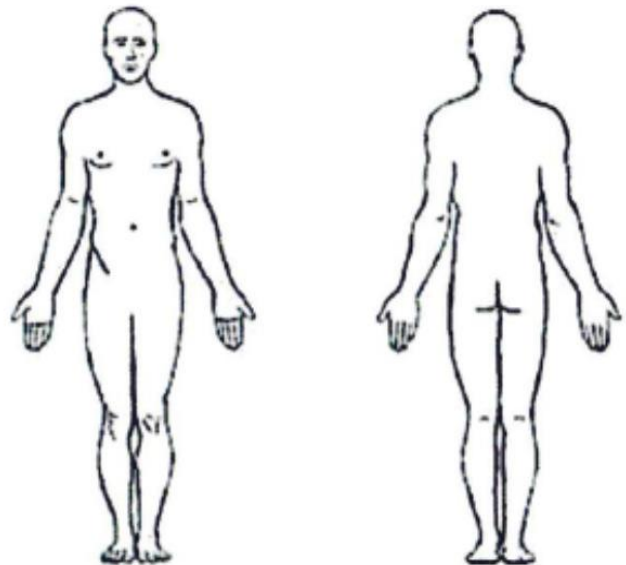
Pain level at **BEST**



Pain level at **WORST**



**Please mark the location of pain with an "X"**



To the best of my knowledge the above information is accurate and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist signature: \_\_\_\_\_ Date: \_\_\_\_\_