Name _____ **Date of Birth** _____ **Date**_____
Height: _____ **Weight:** _____ **MD Follow up Date:** _____

What is your reason for coming to therapy today? _____

Date of injury or when problem began? _____

How did your problem start? ☐ Lifting ☐ Twisting ☐ Falling ☐ Motor vehicle accident ☐ Bending

Describe: _____

What type of hobbies / activities /exercise did you regularly perform (prior to injury) and how often? _____

_____

Have you had any diagnostic tests (x-ray, MRI, CT scan, etc)? _____

_____

Please mark the location of your pain on the chart below.

Pain at **LOWEST**: Rate your lowest pain level in past week
0 = No pain 10 = Worst pain imaginable

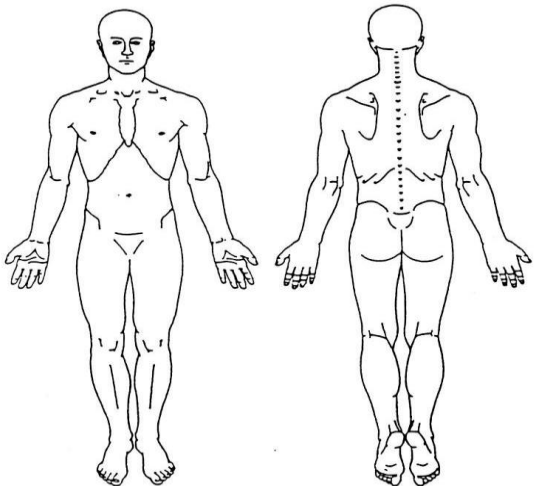
0 1 2 3 4 5 6 7 8 9 10

Pain at **WORST**: Rate your highest pain level in past week.
0 = No pain 10 = Worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Pain **CURRENTLY**: Rate your level of pain at this time.
0 = No pain 10 = Worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10



What makes your pain better? _____ What makes your pain worse? _____

Please **CIRCLE** the areas where you have seen a **DECLINE** in your abilities with your most recent condition.

Working	Lifting	Kneeling	Sleeping / Resting	Dressing / Grooming
Sitting	Carrying	Gripping	Getting in / out of bed	Balance
Standing	Bending	Turning head / trunk	Lying Down	Exercise Routine
Walking	Squatting	Driving	Rising from sitting	Other _____

Does your past medical history include any of the following? (**Circle all that apply**)

Cardiac Problems	High Blood Pressure	Pacemaker	Cancer
Fibromyalgia	Diabetes	Osteoarthritis	Rheumatoid Arthritis
Seizures	Depression	Asthma	Orthopedic Problems
GI Problems	Kidney Problems	Multiple Sclerosis	Muscular Dystrophy
Parkinson's Disease	Drug / Alcohol Dependency	Infectious Disease	Autoimmune Disease
Stroke / TIA	Open Wound	Brain Injury	Concussion
Spinal Cord Injury	COPD	Lung Disease	Pregnancy
Urinary Incontinence	Bowel Incontinence	Pelvic Pain	

BALANCE

☒ Have you had two or more falls within the past year? Yes / No
☒ Have you had one fall resulting in injury within the past year? Yes / No

Please list any major surgeries with dates _____

List allergies (medication, latex, etc)_____

List all medications you are currently taking: ☐ See List attached ☐ None

What are your goals for therapy? _____

PATIENT SIGNATURE_____

Revised: 05/23/2019