

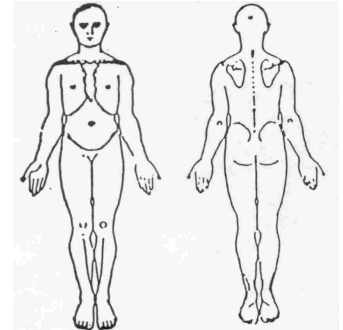


Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Occupation \_\_\_\_\_

- 1. Using the body chart, place an "x" on the area of your pain and/or symptoms.
- 2. Please circle the number that represents your pain level. 0 is no pain and 10 is severe pain.

0 1 2 3 4 5 6 7 8 9 10

- 3. Is your injury related to work, a motor vehicle accident, a recreational accident, or other? (Please circle one)
- 4. What was the specific cause of injury, or the series of events leading up to your visit today? Onset or injury date: \_\_\_\_\_  
Description: \_\_\_\_\_



- 5. Describe how your symptoms progress throughout the day. (For example better, worse, stiff, same)

- 6. Do you wake up during the night because of pain?  No  Yes How many times? \_\_\_\_\_
- 7. Is there any particular activity that aggravates your symptoms? \_\_\_\_\_
- 8. Since your symptoms first started, have they: (circle one) increased, decreased, or stayed the same?
- 9. List medications you are taking now. \_\_\_\_\_

- 10. Please list recent diagnostic tests relating to this injury (CT scan, MRI, x-rays) \_\_\_\_\_

- 11. Please list surgeries you have had. Please give procedure and dates, if possible.

- 12. Do you exercise, and if so what do you do? \_\_\_\_\_

- 13. Do you have any metal (excluding teeth) in your body? (i.e. pins, plates, pacemaker)  No  Yes

- 14. Have you ever had physical therapy treatments before?  No  Yes

If yes, please indicate where, when and for what problem. \_\_\_\_\_

- 15. List any allergies you have \_\_\_\_\_

- 16. Have you ever had the following?
 

a. High blood pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	f. Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes
b. Heart/circulation disorders <input type="checkbox"/> No <input type="checkbox"/> Yes	g. Dizzy Spells <input type="checkbox"/> No <input type="checkbox"/> Yes
c. Arthritis/Osteoarthritis <input type="checkbox"/> No <input type="checkbox"/> Yes	h. Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes
d. Immune deficiency disease <input type="checkbox"/> No <input type="checkbox"/> Yes	i. Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
e. Osteoporosis <input type="checkbox"/> No <input type="checkbox"/> Yes	

- 17. Have you had any recent trouble with vision?  No  Yes

- 18. Have you had any recent trouble with hearing?  No  Yes

- 19. Have you had an unusual weight gain or loss lately?  No  Yes

- 20. Have you ever taken steroids or anti-coagulants for an extended period of time?  No  Yes

- 21. **For women**, are you pregnant?  No  Yes

- 22. Date of your next doctor's appointment \_\_\_\_\_

*Thank you*