Patient Name_____ Date_____

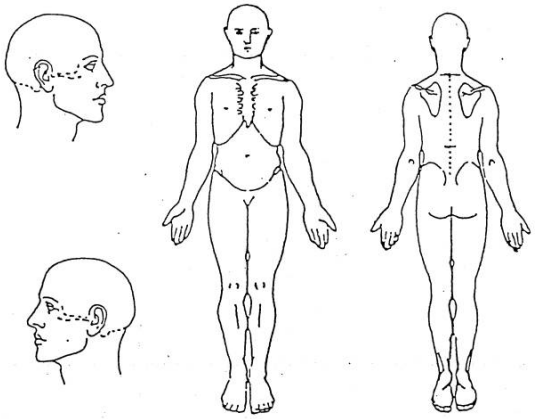
What problem or complaint brings you to Physical Therapy?_____

_____

Have you had any imaging performed? MRI, CT Scan, X-ray, Pet Scan, Ultrasound

When_____

Please indicate areas of symptoms on the diagrams to your right:



Type of Pain: Sharp/ Burning / Aching / Tingling (circle)

Numbness / Other_____

What is your pain intensity?(Circle)

(1= minimum; 10 = severe)

0 1 2 3 4 5 6 7 8 9 10

Is your pain constant or intermittent? (Circle)

My symptoms are: getting better, getting worse, staying the same. (Circle)

How long have you had these symptoms? Did it come on suddenly or gradually?

_____

What activities increase your pain?

_____

What activities decrease your pain?

_____

Does your pain change throughout the day? If so what time of day is best and what time of day is the worst? _____

Does the pain keep you up at night? Y / N Does changing positions relieve the pain ? Y / N

Does taking a deep breath, coughing ,or sneezing increase your symptoms? Y / N

Does bending, sitting, lifting or twisting your back aggravate your symptoms? Y / N

Does eating certain foods make your pain feel worse? Y / N

During the past month have you had little interest or pleasure in doing things? Y / N

During the past month have you been bothered by feeling down, depressed or hopeless ? Y / N

Is this something with which you would like help? Y / N / Yes but not today.

Have you recently noted: (Please circle all that apply)

Weight Loss/Gain	Headaches	Difficulty Sleeping
Muscle Weakness	Cramps in legs while walking	Urinary or bowel change
Pain at night	Fatigue/malaise	Constipation
Nausea/vomiting	Numbness/tingling	Change in Appetite
Fever/Chills/Sweats	Change in Vision or Hearing	Shortness of Breath
Chest Pain	Difficulty swallowing	Difficulty with balance

Do you have now or have you ever had the following? (please circle all that apply)

Surgeries	Loss of consciousness	Depression
Heart problems	Blood Pressure Problems	Diabetes
Circulation problems (blood clots)	Cancer	Lung Disease
Easy bruising/bleeding	Asthma/breathing problems	Liver dysfunction
Indigestion/heartburn	Leg/ankle swelling	Fractures
Urinary Problems/infection	Ulcers/abdominal pain	HIV/STD
Pelvic Inflammatory Disease	Prostate Problems	Osteoporosis
Endometriosis	Arthritis	Abdominal Aneurysm

Please explain and give estimate dates of any items circled above_____

_____

Any previous injury, condition or illness that might affect current care?_____
___

Is there any significant illness or disease of an immediate family member? Y / N If yes, please explain,(Please refer to diseases above)_____

Are you currently taking any medications? Yes / No

Name or type of medication:_____(
If too many to list please provide a separate list with frequency and dosages)

Have you ever taken steroids for an extended time period for any medical condition? Y / N

Are you taking anticoagulants? Including baby aspirin Y/N Do you smoke? Y / N Do you have a pacemaker? Y/N Do you have a defibrillator? Y / N Allergic to latex? Y/N