
Patient First Name

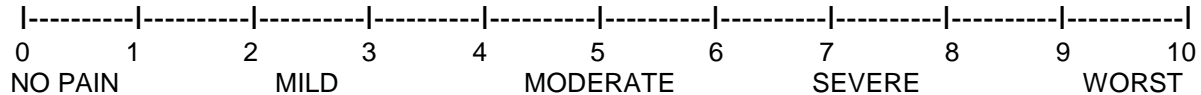
Last Name

Date

Please describe briefly the condition and complaints you need physical therapy for: _____

Where do you have pain? _____

Pain scale: please rate your pain level on a scale from 0 to 10 (circle below):



Functional limitations: I have difficulty with: _____

Have you had any tests done? X-rays MRI CT scan other: _____

Have you had any other treatment for this condition? Yes, _____ No

Please list all the medications (including vitamins & supplements) you take: _____

Please list broken bones (fractures), injuries and motor-vehicle accidents you have had and when: _____

Please list any surgeries you have had and when: _____

Please check and / or list any other medical problems you have had or have now:

- Heart disease Circulatory problems High blood pressure Diabetes
- Seizure disorder Osteoporosis Asthma Cancer
- Other _____

Smoking History: I do NOT smoke I smoke I have been a smoker in the past for ___ years.
Quit smoking date / year: _____

[For females only] I am pregnant or trying to get pregnant NOT pregnant.

My age: _____ My height: _____ My weight: _____ I am Right handed Left handed
My weekly exercise routine consists of: _____

What are your goals / expectations of treatment?: _____

