Name: ______________________________________ Date: ____________________

What is the problem for which you seek Physical Therapy?_____________________________

____

Date of Onset: (Month/Day in the last year):______________________________________

Tell us the history of the problem. ____

____

____

Are you doing anything to treat the problem now? __________________________________

How does the problem affect you during your day and/or night? When do you notice it and what activities does it prevent you from doing?____

____

Have you been treated for this problem before? Yes No

If yes, please explain: (Surgery, Medications, Prior Physical Therapy, Other Treatment)

____

____

What are 3 specific things your are hoping to be able to do better or with less pain after you complete physical therapy?

1.
2.
3.

Work Level: (circle all that apply) Full-time Part-time Light Duty Off Work Retired Unemployed

Work From Home Caring for Children < 6 Years Old Caregiver for Dependent Person Student

Work Activities:____

Height:_________________ **Weight:** __________________ **Do you smoke?** Yes No

Do you exercise beyond normal daily activities? Hrs/day____ Days/wk_______

If yes, what do you do?: ____

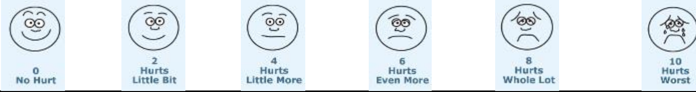
Do you have any customs, religious beliefs or wishes that might affect care? Yes No

If yes, please explain:____

Is there someone who can help if you are unable to complete normal home activities? Yes/No

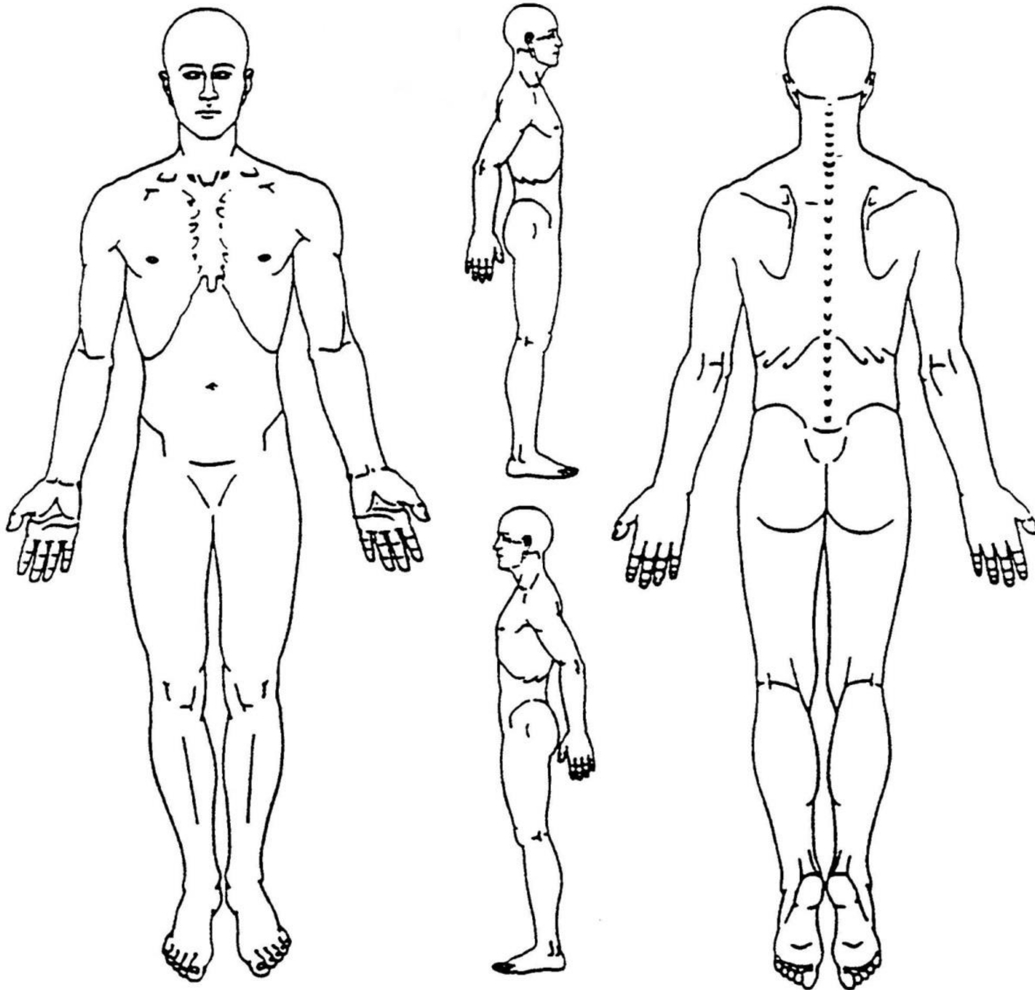
Pain Severity:

PAIN SCALE: 0=No Pain, 10= Worst Pain You Can Imagine



- Worst pain: 0 1 2 3 4 5 6 7 8 9 10
- Best pain: 0 1 2 3 4 5 6 7 8 9 10
- Current pain: 0 1 2 3 4 5 6 7 8 9 10

Area of Pain: Please mark areas of pain (X) and any areas of numbness (●)



- What increases your pain:____
- What relieves your pain: ____

Medical History

Do you have a pacemaker? Yes No

Have you ever had any of the following? (Please include relevant dates)

___ Osteoarthritis: ___________________________
___ Osteoporosis
___ Cardiovascular Disease
___ Diabetes: (Circle) Type 1 Type 2
___ Allergies
___ High blood pressure
___ Current Infection: ______________________
___ Immunosuppression
___ Fracture: ____________________________
___ Cauda Equina Syndrome
___ Heart problems
___ Lung problems
___ Head injury
___ Multiple Sclerosis
___ Parkinson's Disease
___ Urine Leakage or Urgency
___ Bowel Leakage or Urgency
___ Endometriosis
___ Pelvic Congestion
___ Pelvic Inflammatory Disease
___ Vulvodynia
___ Fibroids
___ Pudendal Neuralgia
___ Menopause
___ Dysmenorrhea
___ Blood disorders
___ Depression
___ Kidney problems
___ Stroke
___ Seizures/epilepsy
___ Other Neurological Condition or Injury:____
___ Cancer, what kind: ____
___ Surgery, what kind ____

Women: Are you pregnant or think you might be pregnant? YES NO

Have you had any of the following tests in the past year?

___ MRI
___ Bone scan
___ CT scan
___ Nerve conduction test
___ X-rays
___ Other Test or Imaging: ___________________

Any other information or concerns you feel your therapist should know?________________________

____

Please list all medications and supplements OR provide a list we can copy:

____
____
____
____
____