PERSONAL INFORMATION			
Patient Name	Date of Birth		
Employed? Y N Occupation?	Full Time	Part Time	Retired
Have you **already had** physical therapy in an outpatient office during this calendar year? Y N When? For how long? For What Reason?			
Primary Care Physician			
Referring Physician			
When are you scheduled to see your doctor again?			

PHYSICAL THERAPY INFORMATION		
What is your reason for seeing us today?		
Date of Injury or Change of Condition/Status:		
Treatment side: Rt Lt	Height: _____ft. _____in.	Weight:_____lbs.
History of Falls? Y N Date of Fall(s)		
Are you exercising at home? Y N If yes, what type?		
Any Pertinent Diagnostic Tests Performed: (List dates and types)		
Any Pertinent Surgery Performed: (List dates and types)		
Any Functional Limitations? (Circle all that apply) Sleep/Self Care/Reaching/Pushing/Pulling/Lifting/Carrying/Bending/Sitting/Standing/Walking Squatting/Other(specify)		
Aggravating Factors (circle all that apply) Sitting/Standing/Walking/Stairs-up /Stairs-down/Sit to stand/Bending/Laying/Coughing Sneezing/Other(specify)		
How do you manage your pain? Ice Heat Other(specify)		
Patient Goals/What would you like to gain from PT?		

MEDICAL HISTORY					
Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Heart Disease			Fibromyalgia		
High Blood Pressure			Inflammatory Arthritis		
Pacemaker			Osteoarthritis		
Diabetes			Osteoporosis		
Stroke			Scoliosis		
Neurological Disorders			Mental Health		
Seizures			Hearing Impairment		
Asthma			Visual Impairment		
COPD			Allergies		
Smoker			Pregnant		
Cancer/Chemotherapy/Radiation			Major Surgeries		
Immunocompromised			Other (Specifiy)		
Covid Vaccinated					

MEDICATIONS	**Dosage**	**Frequency**

*To the best of my knowledge, all proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my therapist at my earliest convenience.

PRINTED NAME:_____ **SIGNATURE:**_____

DATE:_____

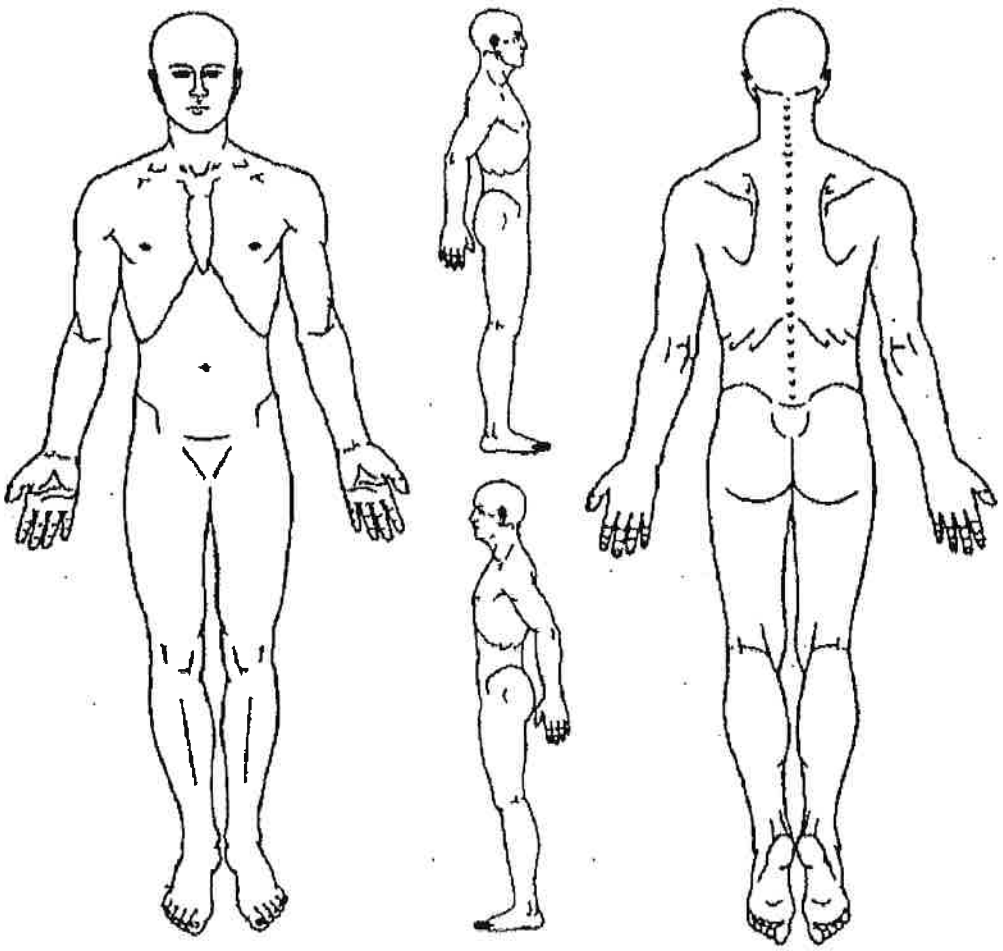
Name:_____
Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now, by using the letters below to indicate the type and location of your sensations.

Key:

A = Aching B =Burning N = Numbeness P = Pins & Needles S = Stabbing O = Other



Rate your pain levels: 0=No Pain, 5=Moderate Pain, 10=Severe Pain

At Worst	0	1	2	3	4	5	6	7	8	9	10
Right Now	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10