

Physician: \_\_\_\_\_  
 Physician's fax: \_\_\_\_\_  
 Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**A. Injury History:**

Describe the physical problem(s) you are having in your own words. From the beginning of your problem(s) to the present time, try to place the events in chronological order.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

1. What started or set off the problem(s)?

- just started suddenly       began gradually       lifting       twisting/bending
- fall       injured at work       pulling       injured during sports
- injured in auto accident       hit from behind       no apparent cause       other: \_\_\_\_\_

2. Approximate date of original pain/symptoms: \_\_\_\_\_ Is this a work related injury?  yes  no

3. Does any member of your family have the same or similar problem(s)?  yes  no

If yes, explain: \_\_\_\_\_

4. Have you been given a diagnosis for this condition?  yes  no If yes, what? \_\_\_\_\_

5. Have you had any of these diagnostic tests (check all that apply)?

- MRI (magnetic resonance imaging)       electromyogram (EMG)       arthrogram or sonogram
- CT (computed tomography) scan       diagnostic x-rays       discogram
- myelogram (x-ray with dye injection)       injections       other \_\_\_\_\_

6. Please indicate the approximate date(s) of your previous treatments/tests, including the name of clinician, what treatments/tests were done, and the results, if known.

Date(s)	Clinicians(s)	Test(s)	Results(s)

7. Please indicate the number of times you have had any of the following treatments for this problem:

- \_\_\_ electrical stimulation      \_\_\_ traction      \_\_\_ cold/hot packs      \_\_\_ massage
- \_\_\_ manipulation      \_\_\_ strength training      \_\_\_ work hardening      \_\_\_ iontophoresis
- \_\_\_ aerobic exercise      \_\_\_ trigger point work      \_\_\_ aquatic therapy      \_\_\_ TENS
- \_\_\_ ultrasound      \_\_\_ myofascial release      \_\_\_ splinting      \_\_\_ other \_\_\_\_\_

8. Have you had surgery for this problem or related problems?  yes  no If yes, how many? \_\_\_ When? \_\_\_\_\_

9. Are your symptoms constant or do they come and go?  constant  come and go

10. What activities make the pain worse (check all that apply)?

- exercise (during)       exercise (after)       lifting       driving       climbing (stairs)
- lying/sleeping       sitting       standing       walking       running
- computer work       writing       bending forward       bending backward       other \_\_\_\_\_

11. What do you do to control the pain or dysfunction (check all that apply)?

- nothing       lie down       sit       stand       walk
- splinting       ice/heat       pain pills       muscle relaxants       aspirin/anti-inflammatory
- injections for pain       manipulation       physical therapy       other \_\_\_\_\_

12. Using the scale below, rate your low pain \_\_\_\_; average daily pain \_\_\_\_; and high pain \_\_\_\_.

No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating				
1	2	3	4	5	6	7	8	9	10

13. Is your pain worse in the:  morning  afternoon  evening  during night  same  varies

14. Check the words that best describe your feelings of discomfort (check all that apply):

sharp/stabbing - S

dull - D

tingling - T

pins & needles - PN

aching - A

heavy pressure - H

burning - B

radiating - R

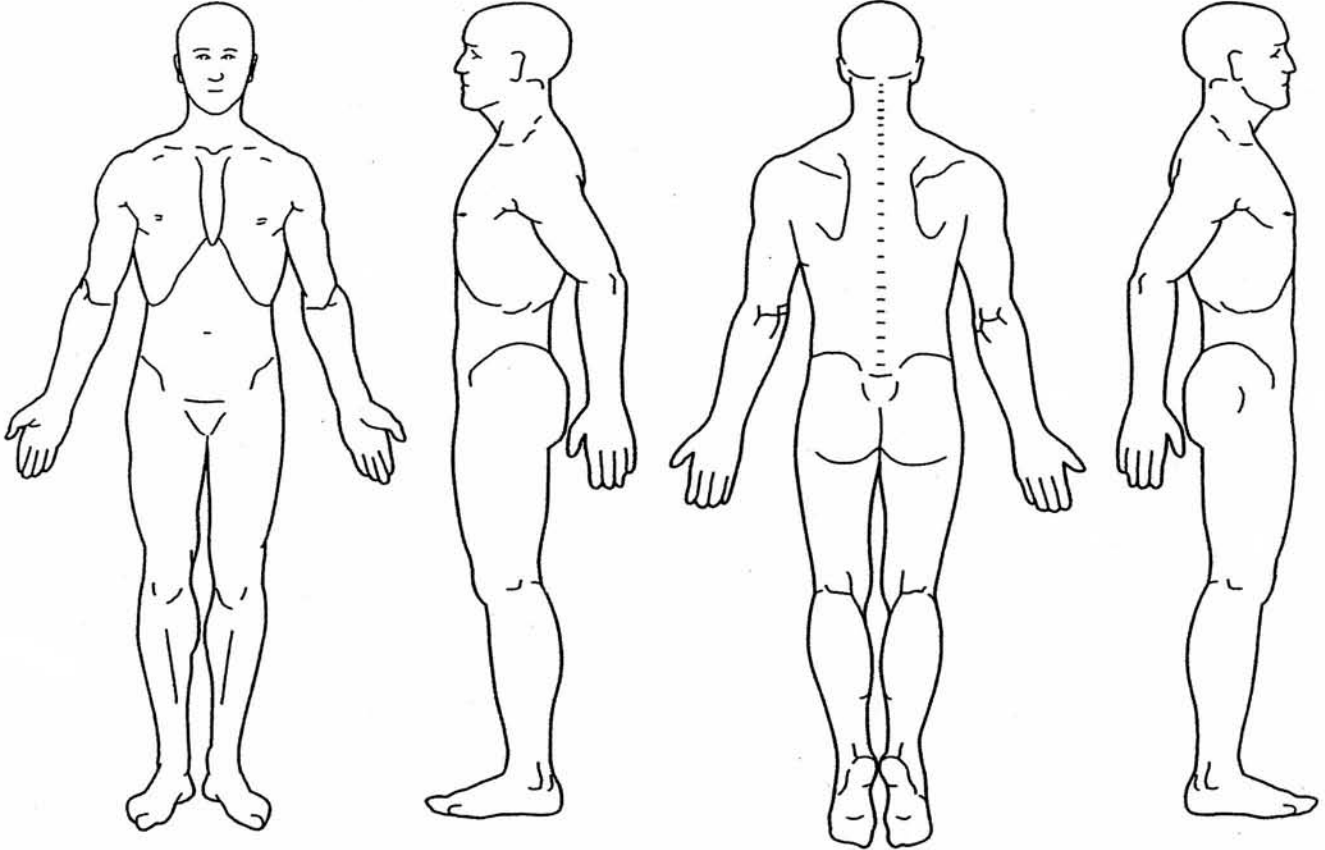
numb - ///

pain - ●

moderate pain - ⊗

severe pain - ≡

15. Using the appropriate letters or symbols following each feeling listed above (in question 14), mark the areas on your body where you feel these symptoms. Mark all affected areas. Circle the area where the pain is most intense.



16. How much knowledge do you feel you have about your injury or condition?

very little

little

some

much

very much

17. Realizing that you are visiting this office for assessment and treatment of your problem(s), do you have an opinion about what should be done to correct your present condition? \_\_\_\_\_

18. By the time you have completed your therapy here, how much improvement do you realistically expect to attain?

less than 20% improvement

20–39% improvement

40–59% improvement

60–79% improvement

80–90% improvement

90–100% improvement

19. Please list the 3 main goals or outcomes you hope to attain as a result of your physical therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## B. Lifestyle:

1. Please note your hobbies, sports, or recreation activities that you like to perform: \_\_\_\_\_

2. Has your current condition/injury prevented you from doing these activities?  yes  no If yes, how?

\_\_\_\_\_  
\_\_\_\_\_

**C. Employment:**

Employer: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

What is your present employment status? (check one)

- Employed and working full duty     
  Employed and working light duty     
  Employed but off work  
 Receiving disability     
  Retired     
  Unemployed     
  Full-time student

Does your job involve (check all that apply):

- Prolonged sitting (desk, computer, driving)  
 Prolonged standing (sales clerk, server)  
 Prolonged walking (delivery service, server)  
 Use of large or small equipment (phone, forklift, computer, cash register)  
 Lifting, bending, twisting, climbing, turning  
 Other (please describe):

**D. Medications:**

1. Please list all medications currently being taken:

Medication	For	Began Taking	Comments

**E. Medical History:**

1. Are you allergic to Latex?  yes  no  
 2. Could you possibly be pregnant?  yes  no  
 3. Have you ever been told you have:

	Date Diagnosed	Comments
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Stroke		
Kidney disease/stones		
Allergies		
Breathing difficulties (asthma, emphysema)		
Ulcers/stomach problems		
Depression		
Chemical dependency (alcohol, drugs)		
Arthritis		
Epilepsy		
Neurological disease (MS, ALS)		
Fibromyalgia		
Headaches		
Osteoporosis/Osteopenia		
Urinary Tract Infection		
Thyroid problems		
Other		