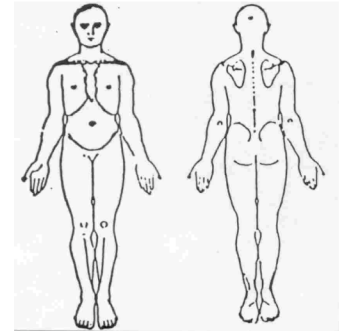


Name \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Occupation \_\_\_\_\_

- Using the body chart, place an "x" on the area of your pain and/or symptoms.
- Please circle the number that represents your pain level. 0 is no pain and 10 is severe pain.

0 1 2 3 4 5 6 7 8 9 10

- Is your injury related to work, a motor vehicle accident, a recreational accident, or other? (Please circle one)
- What was the specific cause of injury, or the series of events leading up to your visit today? Onset or injury date: \_\_\_\_\_  
Description: \_\_\_\_\_



- Describe how your symptoms progress throughout the day. (For example better, worse, stiff, same)

6. Do you wake up during the night because of pain?  No  Yes How many times? \_\_\_\_\_

7. Is there any particular activity that aggravates your symptoms? \_\_\_\_\_

8. Since your symptoms first started, have they: (circle one) increased, decreased, or stayed the same?

9. List medications you are taking now. \_\_\_\_\_

10. Please list recent diagnostic tests relating to this injury (CT scan, MRI, x-rays) \_\_\_\_\_

11. Please list surgeries you have had. Please give procedure and dates, if possible.

12. Do you exercise, and if so what do you do? \_\_\_\_\_

13. Do you have any metal (excluding teeth) in your body? (i.e. pins, plates, pacemaker)  No  Yes

14. Have you ever had physical therapy treatments before?  No  Yes

If yes, please indicate where, when and for what problem. \_\_\_\_\_

15. List any allergies you have \_\_\_\_\_

16. Have you ever had the following?

- |                                |  |
|--------------------------------|--|
| a. High blood pressure         | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| b. Heart/circulation disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| c. Arthritis/Osteoarthritis    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| d. Immune deficiency disease   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| e. Osteoporosis                | <input type="checkbox"/> No <input type="checkbox"/> Yes |

- |                 |  |
|-----------------|--|
| f. Seizures     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| g. Dizzy Spells | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| h. Diabetes     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| i. Cancer       | <input type="checkbox"/> No <input type="checkbox"/> Yes |

17. Have you had any recent trouble with vision?  No  Yes

18. Have you had any recent trouble with hearing?  No  Yes

19. Have you had an unusual weight gain or loss lately?  No  Yes

20. Have you ever taken steroids or anti-coagulants for an extended period of time?  No  Yes

21. **For women**, are you pregnant?  No  Yes

22. Date of your next doctor's appointment \_\_\_\_\_

*Thank you*