

Name: _____

Date: _____

Age: _____ Sex: M F Height: _____ Weight: _____ Dominant hand: R L

WORK INFORMATION: Occupation: _____ Presently working: Y N

HISTORY: How did your problem occur? _____

Date of Onset: _____ Involved Side: R L Both

Describe any previous problems with this area: _____

MEDICAL INFORMATION:

Physician: _____ Diagnosis: _____

Medical Tests: X-Ray ___ CAT Scan ___ Bone Scan ___ MRI ___ EMG ___ Nerve Conduction ___

Arthrogram ___ Other: _____ Results: _____

Did you have surgery? Y N If yes, what was the date: _____

Did you use: Cast ___ Splint ___ Brace ___ Date Applied: _____ Date Removed _____

List any medications you are taking: _____

Have you ever been diagnosed with any of the following conditions?

Y	N	Cancer	Y	N	Multiple Sclerosis
Y	N	Heart Problems	Y	N	Rheumatoid Condition
Y	N	High Blood Pressure	Y	N	Other Arthritic Conditions
Y	N	Circulation Problems	Y	N	Hepatitis
Y	N	Asthma	Y	N	Stroke
Y	N	Emphysema/Bronchitis	Y	N	Kidney Disease
Y	N	Thyroid Problems	Y	N	Anemia
Y	N	Diabetes	Y	N	Osteoporosis/Osteopenia

FUNCTION:

Indicate any activities that you have difficulty completing (Walking, sitting, running, climbing stairs)

What goals do you hope to accomplish with Physical Therapy? _____

PAIN:

Indicate the intensity of your pain at rest- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Is your pain: Constant Intermittent

Activities that increase pain: _____

Activities that decrease pain: _____

Where is your pain? (Please mark on the drawing below the areas where you feel your pain.)

