Name:_____ Date:_____

Age:_____Height:_____Weight:_____Occupation:_____

What recreational / leisure activities do you enjoy?_____

Smoker: Y N Are you pregnant or think you might be pregnant? Y N Recent Steroid Use? Y N

Do you have a pacemaker? Y N

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

Please list all current medications and dosage, including over the counter medications, vitamins, supplements: (may attach separate list)

Past Medical History: Circle all that apply

Cancer	Diabetes	Kidney Disease	Stroke	Ulcers	Seizures
High Blood Pressure	Heart Disease	Angina/Chest Pain	Fibromyalgia	Thyroid	Skin Cancer
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Lyme Disease	HIV	Other_____
Allergies/Asthma	Lung Disease	Liver Disease	Blood clots	Sexually transmitted disease	

Have you RECENTLY noted any of the following (circle all that apply)?

Fatigue	Muscle Weakness	Increased pain at night	Malaise
Shortness of breath	Fever/Chills/Sweats	Balance problems (dizziness)	Recent falls
Nausea/Vomiting	Difficulty swallowing	Headaches	Chest pain
Weight loss/gain	Numbness/Tingling	Changes in bowel or bladder function	Changes in menstrual cycle

During the past month, have you been feeling down, depressed, or hopeless? Y N
During the past month, have you been bothered by having little interest or pleasure in doing things? Y N
Is this something with which you would like help? Yes Yes, but not today No

Current Symptoms

When did your symptoms first begin?_____

How did your symptoms begin? (gradually,suddenly,injury?)_____

Have you had an Xray, MRI, or special testing for this problem?_____

My symptoms are currently: Getting better_____Getting worse_____ Staying the same_____

Have you received any treatment for this problem?_____

Have you had this problem before? Y N How long did it take for you to feel better?_____

Do your current symptoms interfere with your sleep? No problem sleeping_____Difficulty getting to sleep___
Awakened by pain_____Sleep only with meds_____

Body Chart

Please mark the areas where you feel symptoms on the diagram. Use the following symbols to describe your symptoms:

↓ shooting/sharp pain

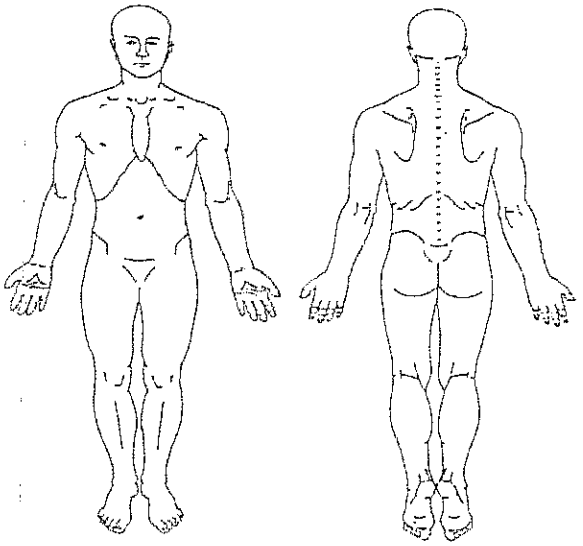
X dull/ aching pain

≈ numbness

ᵛ tingling

My symptoms: Come and go___Are constant_____

Are constant, but change with activity_____



For the therapist:

+/- Cough/Sneeze, +/- Saddle Anesthesia, +/- Bowel/Bladder Changes

On the scale below, please circle the number which best describes your pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

In the past 24 hours rate your pain at its least_____At its worst_____

Is there anything you can do to reduce your symptoms?_____

Is there anything that makes your symptoms worse?_____

Do any of these activities make your pain worse? Lying down___Standing___Walking___Sitting___Squatting

What time of day do you feel your best? AM_____ Afternoon_____PM_____After exercise_____

What time of day do you feel your worst? AM_____Afternoon_____PM_____After exercise_____

The Patient-Specific Functional Scale

Please identify three important activities that you are unable to do or are having difficulty with as a result of your current symptoms and list them below:

1.)	
2.)	
3.)	

In the right hand column above, please rate your ability to perform these activities based on the scale below:

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury or problem

What do you hope to accomplish in physical therapy?_____