Name: ______________________________Age__________ SSN:__________________ Date:_____________

Gender M F Height_____ Weight_____

Leisure/exercise routines____ Occupation:_________________
Smoker? Y N Are you latex sensitive? Y N Pacemaker? Y N Pregnant? Y N

Have you fallen within the past 12 months? Y N If so, how many times _______? Were you injured? Y N

ALLERGIES: List any medication you are allergic to: ____

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

- ❑ **Unexplained weight loss/gain**
- ❑ **Fever/chills/sweats**
- ❑ **Difficulty swallowing**
- ❑ **changes in bowel or bladder function**
- ❑ **Increased pain at night**
- ❑ **Decreased memory/ability to think**
- ❑ **Blood in your sputum**
- ❑ **Difficulty sleeping**
- ❑ **numbness or tingling**
- ❑ **shortness of breath**
- ❑ **dizziness/lightheadedness/fainting**
- ❑ **nausea/vomiting**
- ❑ **muscle weakness**
- ❑ **persistent cough**
- ❑ **unusual menstrual or pelvic pain**
- ❑ **throbbing/pulsating pain**
- ❑ **falls or poor balance**
- ❑ **changes in appetite**
- ❑ **headaches**
- ❑ **constipation/ diarrhea**
- ❑ **heartburn/indigestion**
- ❑ **chest/arm/jaw pain**
- ❑ **visual problems**
- ❑ **swelling in legs**

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ **Cancer**
- ❑ **Heart problems**
- ❑ **Chest pain/angina**
- ❑ **High blood pressure**
- ❑ **Circulation problems**
- ❑ **Heart Arrhythmia**
- ❑ **Chemical dependency (alcoholism, drugs)**
- ❑ **Fibromyalgia**
- ❑ **depression/anxiety**
- ❑ **lung problems**
- ❑ **stroke**
- ❑ **Parkinson's disease**
- ❑ **osteo/rheumatoid arthritis**
- ❑ **Neuropathy**
- ❑ **Liver problems**
- ❑ **Other**_______________
- ❑ **thyroid**
- ❑ **diabetes**
- ❑ **osteoporosis**
- ❑ **multiple sclerosis**
- ❑ **epilepsy/seizures**
- ❑ **bone or joint infection**
- ❑ **blood clots**
- ❑ **Other**______________

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ **cancer**
- ❑ **heart problems**
- ❑ **high blood pressure**
- ❑ **diabetes**
- ❑ **stroke**
- ❑ **depression**
- ❑ **Thyroid problems**
- ❑ **blood clots**

During the past month have you been feeling down, depressed or hopeless? YES NO
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
Would you be interested in our exercise program? Y N

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ______________________ **2.**_________________________ **3.**______________________________

4. ______________________ **5.** _________________________ **6.**______________________________

Have you ever taken steroid medications for any medical conditions? YES NO
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO
Have you fallen or had trauma recently YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _______________________ 2.__________________________ 3._______________________________

CURRENT SYMPTOMS
Post surgical? Y N If yes, what was the procedure?____________________________Date?_________

Where are you currently experiencing symptoms?____
How did your symptoms start?____

What do YOU think caused your symptoms? ____

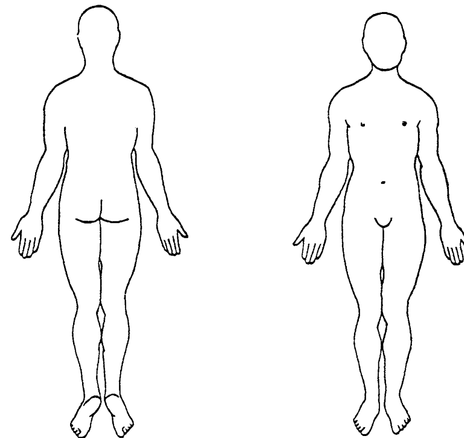
My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying the same
My pain wakes me in the night. ❑ Disagree ❑ Unsure ❑ Agree

If you have received treatment for this problem, by whom? ____________________________________

Please list special tests performed for this problem (x-ray, MRI, labs, etc) ______________________________
Have you ever had this problem before: ❑ Yes ❑ No When__________ Treatment rec'd________________
What are your goals fromTherapy?____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ Shooting/sharp pain
O Dull/aching pain
||| Numbness
= Tingling

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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What position or activity makes your pain worse?____
What position or activity makes your pain better?____
When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity

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On the scales below, please circle the number which best represents the severity of your pain.

Average pain for the last 48 hours:
NO PAIN 0 1 2 3 4 5 6 7 8 9 1 0 WORST PAIN IMAGINABLE

The worst pain you have felt the last 48 hours:
NO PAIN 0 1 2 3 4 5 6 7 8 9 1 0 WORST PAIN IMAGINABLE

Please circle the number below which best represents your overall level of function:
Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

For the Therapist
+-Cough/Sneeze +-Saddle anesthesia +-DVT +-cervical artery +-pulm emb +- Cauda equina