



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)?

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

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> depression/anxiety | <input type="checkbox"/> thyroid |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> stroke | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> osteo/rheumatoid arthritis | <input type="checkbox"/> epilepsy/seizures |
| <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> bone or joint infection |
| <input type="checkbox"/> Chemical dependency (alcoholism, drugs) | <input type="checkbox"/> Liver problems | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

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

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | |

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

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? _____

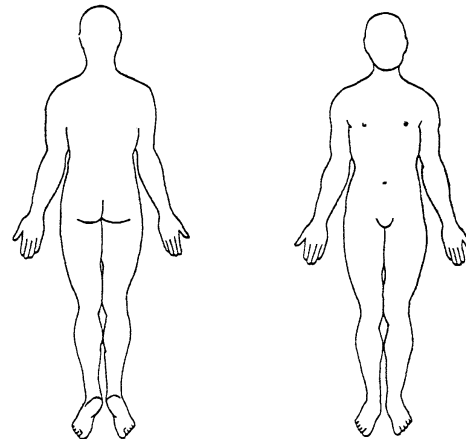
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

What are your goals from Therapy? _____

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

○ Dull/aching pain

||| Numbness

= Tingling

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

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

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 10 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 10 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