

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Type of Injury / Condition \_\_\_\_\_

Onset / Injury Date \_\_\_\_\_

Type of Surgery & Date \_\_\_\_\_

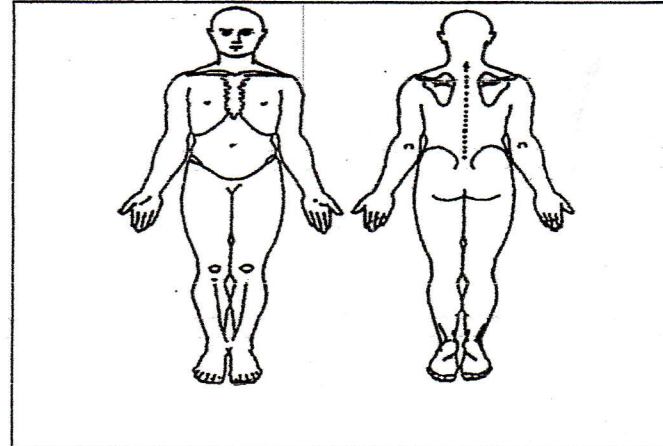
Next Doctor's Appointment? \_\_\_\_\_

Describe previous treatment for this condition \_\_\_\_\_

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



**Please mark the area(s) of concern**

**Have you had any imaging performed:**

- X-Ray
- MRI
- CT Scan
- Doppler
- Ultrasound

**Have you recently noted:**

- Weight Loss /Gain
- Weakness
- Pregnant / IUD
- Pain At Night
- Nausea / Vomiting
- Fever / Chills / Sweats
- Headaches
- Cramps In Legs When Walking
- Fatigue
- Numbness / Tingling
- Change In Vision Or Hearing
- Insomnia

**Do you have now or have you ever had any of the following?**

- Surgeries
- Sprains / Strains
- Heart Problems
- Circulation Problems / Clots
- Easy Bruising / Bleeding
- Indigestion / Heartburn
- Any previous injury that may affect current care \_\_\_\_\_
- Loss of Consciousness
- Diabetes
- Cancer
- Asthma / Breathing Problems
- Leg / Ankle Swelling
- Fainting
- Fractures
- Blood Pressure Problems
- Motor Vehicle Accident
- Lung Disease
- Urinary Problems / Infections
- Allergies / Skin Sensitivity

Explain & give approximate dates for any items indicated above \_\_\_\_\_

Are you currently taking medications? Yes / No Name or Type of Medication \_\_\_\_\_

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other \_\_\_\_\_

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? \_\_\_\_\_

What are your physical or fitness goals: \_\_\_\_\_

Is there anything else you would like to include or ask your physical therapist? \_\_\_\_\_