

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

Type of Injury / Condition \_\_\_\_\_ Onset / Injury Date \_\_\_\_\_

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

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

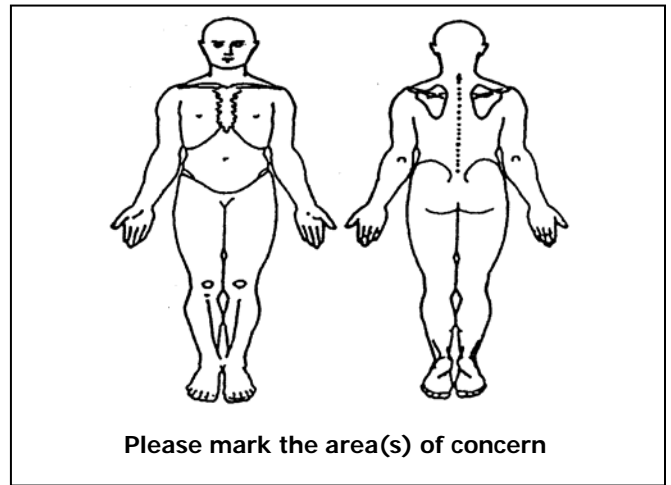
Describe previous treatment for this condition \_\_\_\_\_

\_\_\_\_\_

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



**Have you had any imaging performed:**

- |                                |                                     |
|--------------------------------|-------------------------------------|
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> CT Scan    |
| <input type="checkbox"/> MRI   | <input type="checkbox"/> Doppler    |
|                                | <input type="checkbox"/> Ultrasound |

**Have you recently noted:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Weight Loss /Gain | <input type="checkbox"/> Nausea / Vomiting           | <input type="checkbox"/> Fatigue                     |
| <input type="checkbox"/> Weakness          | <input type="checkbox"/> Fever / Chills / Sweats     | <input type="checkbox"/> Numbness / Tingling         |
| <input type="checkbox"/> Pregnant / IUD    | <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Change In Vision Or Hearing |
| <input type="checkbox"/> Pain At Night     | <input type="checkbox"/> Cramps In Legs When Walking | <input type="checkbox"/> Insomnia                    |

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

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

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 (average) on a 1-10 scale (1=minimal 10=severe) \_\_\_\_\_

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

\_\_\_\_\_

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

In 6 Months \_\_\_\_\_

In 12 Months \_\_\_\_\_

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