



In order to provide you with the utmost quality care, it is important for us to have information on your health history. It will remain a confidential part of your Medical Record. **Please help us by filling out this form COMPLETELY.**

Name: _____ Date: _____

When and what do you think initially caused your pain? Date pain started: _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Reason for Physical Therapy? _____

What are your goals for PT? _____

What leisure activities would you like to return to? _____

Are you employed? Yes No Are you off of work due to your injury? Yes No

Is this a work related injury? Yes No Occupation _____

If out of work due to this injury when do you plan on returning? _____

Date of last x-ray _____ MRI _____ CT _____

Are you currently seeing any of the following? (Please Circle)

Dentist Psychiatrist / Psychologist Occupational Therapy Chiropractor Neurologist
 Massage Therapy Physical Therapist (Other than at Advanced Physical & Sports Therapy)

Please check yes or no if you have now, or in the past, experienced any of the following:

Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neck Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Circulation problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pregnancy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you currently Pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Clots	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bowel / Bladder problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fracture	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of Breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alcoholism	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chemical Dependency	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting / Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Raynaud's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Multiple Sclerosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatoid Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other Arthritic Conditions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Implants of any type	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hypoglycemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you allergic to bee stings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Concussion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you feel safe at home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you in a relationship where you are being hit, kicked, slapped or otherwise hurt?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you checked yes to any of the above please comment: _____

Please list any surgeries, injuries, accidents or other conditions for which you have been treated or hospitalized including the approximate date and reason:

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

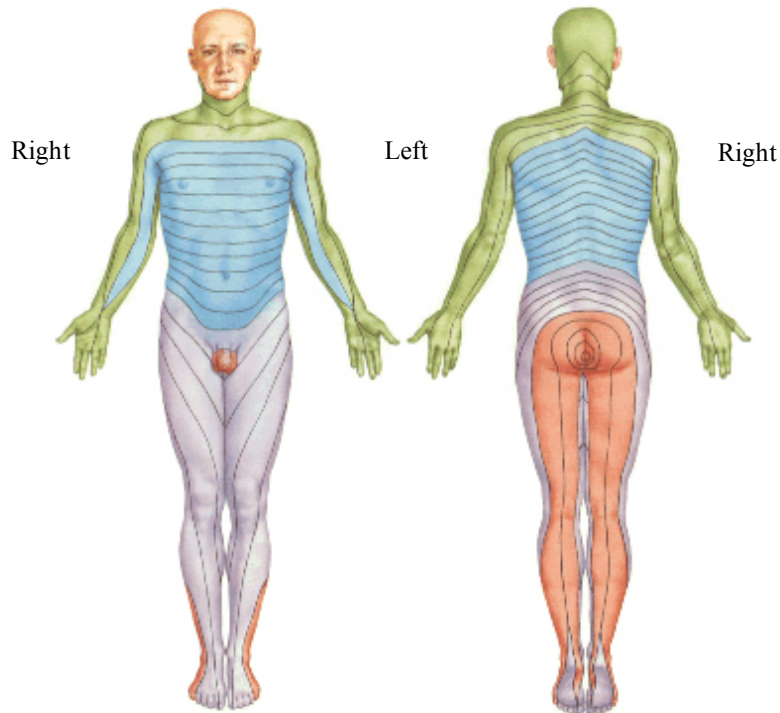
Please list any and all PRESCRIPTION medication that you are currently using (INCLUDING pills, injections, and or patches) How many mg and frequency:

Have you recently noted:

Unexplained Weight loss/gain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fever / Chills / Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Nausea / vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Numbness / Tingling	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is your sleep interrupted by pain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If so, how many times / night?	1-2	3-5	6-9	>10

Please **shade in area where you are experiencing pain / symptoms**. Then use the following descriptions with **arrows and the numbers corresponding to the symptoms listed below to point to the shaded areas** to help us understand your symptoms. Please indicate if you have any surgical scars on your body.

1. Stiffness
2. Swelling
3. Lack of full motion
4. Weakness
5. Numbness
6. Tingling
7. Cramping
8. Paralysis
9. Cold



Pain Scale:

Please circle the number which corresponds most accurately with the **worst pain** you have experienced in the last week).
 No pain **0 1 2 3 4 5 6 7 8 9 10** Need emergency room care

(Please circle the number which corresponds most accurately with the **least pain** you have experienced in the last week)
 No pain **0 1 2 3 4 5 6 7 8 9 10** Need emergency room care

(Please circle the number which corresponds most accurately with the **average pain** you experience **while doing normal daily activities**)
 No pain **0 1 2 3 4 5 6 7 8 9 10** Need emergency room care

I certify that this is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____