

**Patient Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

*This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.*

**Age** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**What is your chief complaint?** (diagnosis, symptoms or condition) \_\_\_\_\_

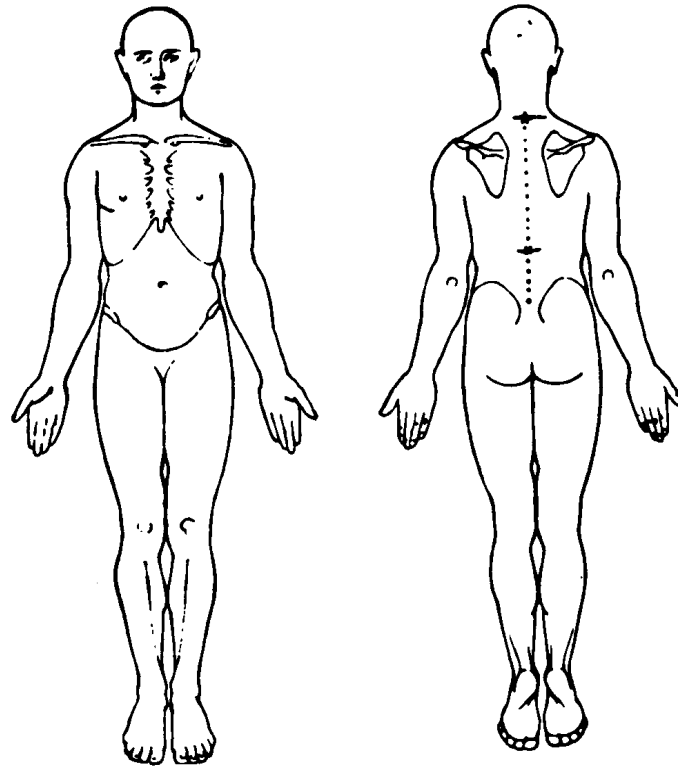
**Draw your area of symptoms**

**Do you now have:**

- \_\_\_ dizziness / fainting / seizures
- \_\_\_ night pain
- \_\_\_ numbness / weakness
- \_\_\_ shortness of breath
- \_\_\_ fever / chills
- \_\_\_ bowel/bladder control problems
- \_\_\_ numbness in the genital area
- \_\_\_ are you pregnant
- \_\_\_ poor circulation / bruising
- \_\_\_ artificial joints
- \_\_\_ unexplained muscle weakness

**Have you ever had:**

- \_\_\_ cancer (type: \_\_\_\_\_)
- \_\_\_ heart problems / pacemaker
- \_\_\_ high blood pressure
- \_\_\_ diabetes
- \_\_\_ rheumatoid arthritis
- \_\_\_ tuberculosis / hepatitis / HIV
- \_\_\_ osteoporosis
- \_\_\_ asthma
- \_\_\_ stroke
- \_\_\_ chest pain
- \_\_\_ fainting or dizziness



Does pain awaken you at night?  No  Yes    Do you smoke?  No  Yes    Unexplained weight loss?  No  Yes

What test have you had for this problems?  x-ray  MRI  CT scan  other \_\_\_\_\_

Have you ever had surgery for this problem?  No  Yes    List other surgeries \_\_\_\_\_

Are you feeling a high level of stress or anxiety?  No  Yes    Have you had difficulty with depression  No  Yes

List the medication you take \_\_\_\_\_

**How would you rate your PAIN? (0 to 10: 0 = no pain, 10 = unbearable pain)**

Right now \_\_\_\_\_ At Best \_\_\_\_\_ At Worst \_\_\_\_\_

**What activities are the most troublesome for you? (circle any that apply)**

- Sleeping, bed mobility, dressing, bathing, other \_\_\_\_\_
- Sitting, standing, walking, bending/lifting, housework, computer, reaching, other work \_\_\_\_\_
- Sports – running, jumping, change of direction, other \_\_\_\_\_

**Is there a physical reason not mention here why you should not follow an activity/ exercise program?**

If yes, please explain: \_\_\_\_\_