

II. Patient Information

Date: _____

Patients: Please complete this form before meeting with your therapist.

B.1a First Name	B.1b Middle Initial	B.1c Last Name
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When do you see your referring doctor again? _____

When did your current symptoms start? _____

How were you injured? _____

What is your main goal for Therapy? _____

c.1 Primary Condition

What are the main health conditions for which/reasons why you are receiving therapy?
Check all that apply.

Check all that apply.	Problems of the muscles, ligaments, joints and/or bones	
	<input type="checkbox"/> a. General <input type="checkbox"/> b. Head and/or neck <input type="checkbox"/> c. Back and/or pelvis <input type="checkbox"/> d. Ribs and/or collarbone <input type="checkbox"/> e. Hip	<input type="checkbox"/> f. Knee, leg, and/or foot <input type="checkbox"/> g. Shoulder <input type="checkbox"/> h. Elbow <input type="checkbox"/> i. Wrist, hand, and/or fingers
	Other problems:	
	<input type="checkbox"/> j. General weakness <input type="checkbox"/> k. Problem with walking or balance <input type="checkbox"/> l. Problem of the heart and/or blood vessels <input type="checkbox"/> m. Problem of the lungs and/or breathing <input type="checkbox"/> n. Problem of the nervous system <input type="checkbox"/> o. Problems with eyes, inner ear, or ears	<input type="checkbox"/> p. Wound and/or skin problem <input type="checkbox"/> q. Mental health condition <input type="checkbox"/> r. Cancer <input type="checkbox"/> s. Communication, voice, or speech disorder <input type="checkbox"/> t. Swallowing disorder <input type="checkbox"/> u. Other condition(s)

Please list all of your previous surgeries: _____

Please list all of your current medications: _____

II. Patient Information (cont.)

c.5 Other Medical Conditions

Has a doctor or other health professional ever told you that you have any of the following conditions? Please check all that apply.

- a. Arthritis (rheumatoid and/or osteoarthritis)
- b. Osteoporosis
- c. Asthma
- d. Chronic obstructive pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS), emphysema, or asthma
- e. Chest pain from your heart (such as angina)
- f. Difficulty breathing or swelling in your legs because of your heart (such as congestive heart failure)
- g. Heart attack (myocardial infarct)
- h. Multiple sclerosis (MS), Parkinson's, or any other neurological condition
- i. Stroke or transischemic attack (TIA)
- j. Peripheral vascular condition
- k. Diabetes
- l. Ulcer, hernia, reflux, or any other upper gastrointestinal condition
- m. Depression
- n. Anxiety or panic disorders
- o. Cataracts, glaucoma, macular degeneration, loss of visual field, or any other visual impairment
- p. Spine/back problem, spinal stenosis, severe chronic back pain, or any other degenerative disc condition
- q. High blood pressure
- r. Headaches
- s. Kidney, bladder, prostate, or urination problems
- t. Allergies
- u. Incontinence
- v. Hepatitis
- w. HIV/AIDS
- x. Prostheses or implants
- y. Sleep dysfunction
- z. Cancer
- aa. Other disorders: Please write in _____

It is our policy to provide Cardio-Pulmonary Resuscitation (CPR) when deemed medically necessary. If these are not your wishes, we must have a valid copy of your Living Will on file.

Please acknowledge: _____

Patient Signature

II. Patient Information (cont.)

E. Pain or Hurting

E.1 Pain Presence or Hurting Have you had pain or hurting at any time during the last 7 days?	Yes	No	Don't know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Range: Over the last 7 days, what has your pain ranged from on a 0-10 scale? Check the box indicating the least pain you have had over the past 7 days, and check the box indicating the most pain you have had over the past 7 days. (0 = no pain, 10 = worst pain you can imagine)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain			Worst Pain			

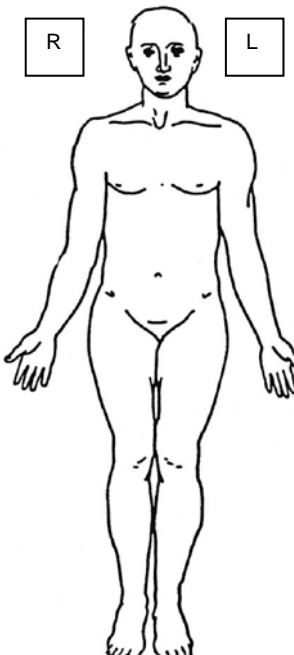
E.3 Please describe your pain or hurting. (Check all that apply.)

Check all that apply.	<input type="checkbox"/> a. Constant	<input type="checkbox"/> e. Burning	<input type="checkbox"/> i. Ache/Throb	<input type="checkbox"/> m. Tightness
	<input type="checkbox"/> b. Intermittent	<input type="checkbox"/> f. Pinching	<input type="checkbox"/> j. Stabbing	<input type="checkbox"/> n. Stiffness
	<input type="checkbox"/> c. Sharp	<input type="checkbox"/> g. Numbness	<input type="checkbox"/> k. Pulling	<input type="checkbox"/> o. Other: Please write in
	<input type="checkbox"/> d. Dull	<input type="checkbox"/> h. Tingling	<input type="checkbox"/> l. Cramping	_____

E.4 Pain/Hurting Location

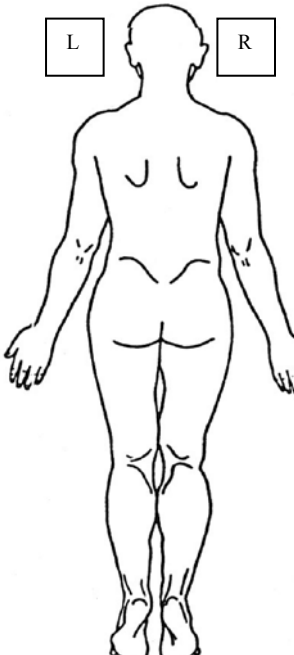
Please mark with an X the area(s) of your body where you have pain or hurting.

R



L

L



R

During the past 2 days, has pain made it hard for you to sleep?
 ___No ___Yes

During the past 2 days, have you limited your activities because of pain?
 ___No ___Yes

What days are you available for Therapy?
 ___Any Day ___Mondays ___Tuesdays ___Wednesdays ___Thursdays ___Fridays

What time of day is best for Therapy?
 ___Anytime ___Early Mornings ___Late Mornings ___Early Afternoons ___Late Afternoons

Is there anything else your therapist should know before therapy begins?