

Patient Name _____ Age _____

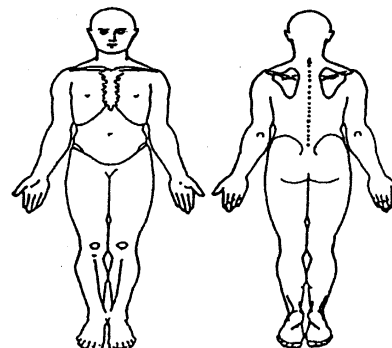
Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition _____



Have you 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 (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? _____
