Patient Name_____ Birth date_____/_____/_____ Male____Female_____
Diagnosis/pro_____ Onset of injury _____
Referring physician _____ ph ( ) _____ fax ( ) _____

MEDICAL HISTORY

Allergies	O Yes O No	Depression	O Yes O No	Multiple Sclerosis	O Yes O No
Anemia	O Yes O No	Diabetes	O Yes O No	Osteoporosis	O Yes O No
Anxiety	O Yes O No	Dizzy Spells	O Yes O No	Parkinsons	O Yes O No
Arthritis	O Yes O No	Emphysema/Bronchitis	O Yes O No	Rheumatoid Arthritis	O Yes O No
Asthma	O Yes O No	Fractures	O Yes O No	Seizures	O Yes O No
Cancer	O Yes O No	Gallbladder Problems	O Yes O No	Speech Problems	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Strokes	O Yes O No
Cardiac Pacemaker	O Yes O No	High Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Chemical Dependency	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Circulation Problems	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Currently Pregnant	O Yes O No	Metal Implants	O Yes O No		

Describe any other conditions or precautions:

Falls History:
Injury as a result of a fall in the past year? ☐No ☐Yes Date of Fall:_____
Two or more falls in the last year? ☐No ☐Yes Dates of Falls:_____

Surgical History:
Body Region: _____ Surgery Type: _____Date of Surgery:_____
Body Region: _____ Surgery Type: _____Date of Surgery:_____

Current Medications:
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____

What body part(s) are you being referred for: _____
Injury Date (if applicable) _____ Please Circle: Work injury, Motor Vehicle Accident, Other
Did this injury require surgery? _____ Kind of surgery and date: _____
Please mark on the scale below your pre-injury level of function: (please circle)

1%-----10%-----20%-----30%-----40%----50%-----60%-----70%-----80%-----90%-----100%

Please mark on the scale below your present level of function: (please circle)
1%-----10%-----20%-----30%-----40%----50%-----60%-----70%-----80%-----90%-----100%

Please describe the location of your pain:_____
Please indicate which of these words, if any, describe your pain. Check all that apply
☐Throbbing ☐Sharp ☐Aching ☐Tingling ☐Burning ☐Numb ☐Shooting
Rate your pain intensity on a scale of 1-10. (0 being no pain) _____
Current pain = ___/ 10, at best = ___ / 10, at worst = ___ / 10
Which activities increase your symptoms? Check all that apply. ☐Sitting ☐Walking ☐Driving ☐Kneeling ☐Twisting
☐Standing ☐Reaching ☐Stairs ☐Reclining ☐Lifting ☐Bending ☐Squatting ☐Rising ☐Other
_____

What eases your symptoms? ☐Moist heat ☐Ice application ☐Medication ☐Rest ☐Change in position ☐Other
_____

Is your condition overall: ☐Improving ☐Getting worse ☐Staying the same
Have you had any treatment of this current problem in the past? ☐Yes ☐No
Have you received any of the following tests for this problem? ☐X-ray ☐CT Scan ☐Bone Scan ☐EMG
☐Nerve Conduction Study ☐MRI ☐Other _____