

# PT WORKS

experience effective physical therapy

Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Work Status: Full Light Off Physician: \_\_\_\_\_

Onset date: \_\_\_\_\_ Cause of Injury: \_\_\_\_\_

Previous Treatment for this condition: \_\_\_\_\_

Additional tests completed (i.e. x-ray, MRI): \_\_\_\_\_

### Medical History (Please circle all that apply)

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

### Describe any other conditions or precautions:

### Fall History

Injury as a result of a fall in the past year? \_\_\_\_\_ Date of Fall \_\_\_\_\_

Two or more falls in the last year? \_\_\_\_\_ Date of Fall \_\_\_\_\_

### Surgical History

Body Region \_\_\_\_\_ Surgery Type \_\_\_\_\_ Date of Surgery \_\_\_\_\_

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### Current Medications

Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Reason for Taking \_\_\_\_\_

Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Reason for Taking \_\_\_\_\_

Drug \_\_\_\_\_ Dosage \_\_\_\_\_ Reason for Taking \_\_\_\_\_

Please rate your pain/discomfort felt in **the last 24 hours**: None 1 2 3 4 5 6 7 8 9 10 Severe

Please rate your pain/discomfort felt in **the last 2 weeks**: None 1 2 3 4 5 6 7 8 9 10 Severe

Please indicate where you have pain or other symptoms:

Key:

Severe Pain \*\*\*\*\*

Moderate Pain 00000

Dull Ache ΔΔΔΔΔ

Radiation Pain ↑↑↑↓↓↓

Numbness/Tingling XXXXX

