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

Office Use Only: Height _____inches Weight_____lbs. weight/height^2 = _____ x 703 = BMI - _____

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_____

Body Region_____ Surgery Type_____ Date of Surgery_____

Current Medications

Drug_____ Dosage_____ Reason for Taking_____

Drug_____ Dosage_____ Reason for Taking_____

Drug_____ Dosage_____ Reason for Taking_____

Please rate your pain/discomfort felt **today**: 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	XXXX