The treatment you need, the care you deserve.

# Pearson PHYSICAL THERAPY

**For Office Use Only**

- Pre-Authorization _____ Visits
- Medicare Cap Status $_____
- BMI _____

| | | | |
|---|---|---|---|
| Name | | Today's Date | |
| Occupation | Age | Weight | Height |
| Primary Care Physician | Referring Physician | | |

PLEASE COMPLETE THE FOLLOWING:

Have you fallen in the last year? _____Yes _____No Injury due to a fall? _____Yes_____No

List the areas to be treated:_____

What is the primary problem?_____

What date did it begin_____Have you had this problem before?_____

Was there a particular incident, surgery or accident involved, or did it come on gradually?_____

_____

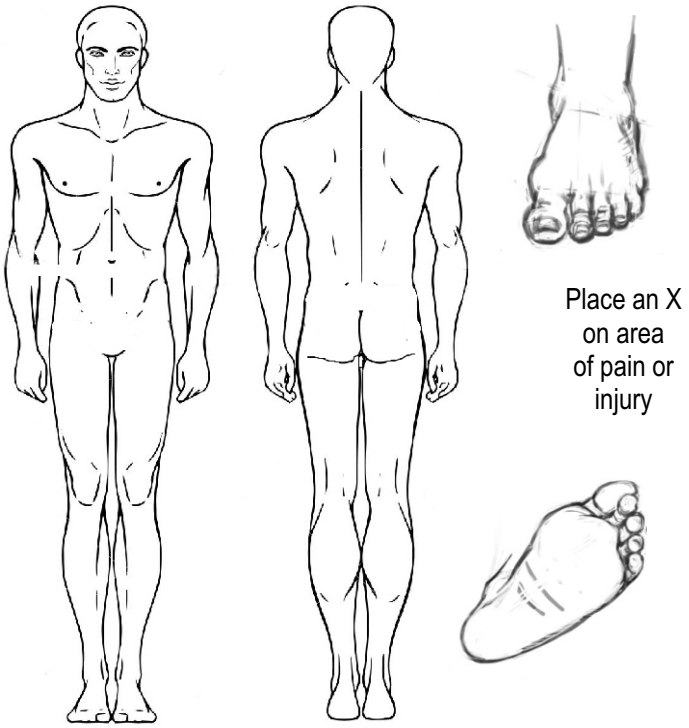
Briefly describe what happened _____

If it was a car accident, were you the driver or the passenger?_____

Rate your pain level on a scale from 0-10. Place a "W" anywhere along the following scale to rate your pain level when your condition is the worst. Draw a "C" to rate your current pain level. Then draw a "B" to rate your pain level at it's least. (10 means you have to go to the emergency room NOW).

0 —— 1 —— 2 —— 3 —— 4 —— 5 —— 6 —— 7 —— 8 —— 9 —— 10

No Pain Emergency Room Pain



Place an X on area of pain or injury

Pharmacy:_____

Current Medications:

| |
|---|
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| |

(over)

What are your goals for Physical Therapy?_____

Which activities, positions, or treatments ( if any) aggravate your problem the most, or are the most painful?

_____

Which activities, positions or treatments give you the most relief?_____

_____

Please list three activities which are more difficult or more painful than before this condition occurred?

1._____

2._____

3._____

Circle if you have had any of the following, and if so explain:

Heart problems_____ Lung Problems_____

Cancer_____ Diabetes_____

High Blood Pressure_____ Fibromyalgia_____

Arthritis_____ Metallic Implant_____

Osteoporosis_____ Pacemaker_____

Currently pregnant_____ Other_____

_____

_____

Latex Allergy_____

Other Allergies (list)_____

Circle all surgeries you have had, and list dates:

Gall Bladder_____Appendectomy_____Hernia_____Mastectomy_____

Hysterectomy_____C-section_____Heart Surgery_____Bowel Resection_____

List other surgeries with dates

_____

Have you had an X-ray, MRI, or CT scan for your problem? If so, where & when was it done? _____

_____

**Circle** if you are currently receiving any of the following, and list where.

Physical Therapy _____Occupational Therapy_____

Speech Therapy_____Habilitative Services_____

Chiropractic _____Osteopathic Physiotherapy_____

Are you currently receiving Home Health Services? _____yes_____no

*Occasionally we have students here that are observing or completing requirements for school. Any student is under supervision of a licensed physical therapist. By signing below, you would give any such student permission to observe and /or participate in you care. Of course, you would always have the right to request that a student not be involved in any aspect of your treatment at any time by informing our staff.*

Signature_____Date_____