Patient Name:_____ Insurance Company:_____

Date:_____ Date of Birth/Age:_____ Patient ID #:_____

ICD-10 Code(s):_____ Diagnosis:_____

Referring Physician:_____ Next follow-up Date:_____

Are you latex sensitive? ☐ Yes ☐ No Do You Smoke? ☐ Yes ☐ No Do You have a pacemaker? ☐ Yes ☐ No

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**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? ☐Yes ☐ No

**ALLERGIES:** List any medication(s) you are allergic to: _____

**Have you RECENTLY noted any of the following (check all that apply)?**

☐ fatigue ☐ numbness or tingling ☐ fever/chills/sweats ☐ muscle weakness ☐ nausea/vomiting ☐ fainting ☐ falls

☐ dizziness/lightheadedness ☐ shortness of breath ☐ weight loss/gain ☐ balance problem ☐ difficulty swallowing

☐ cough ☐ changes ☐ in bowel or bladder function ☐ headaches

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

☐ cancer ☐ depression ☐ thyroid problems ☐ heart problems ☐ lung problems ☐ diabetes ☐ chest pain/angina

☐ tuberculosis ☐ osteoporosis ☐ high blood pressure ☐ asthma ☐ multiple sclerosis ☐ circulation problems

☐ rheumatoid arthritis ☐ epilepsy ☐ blood clots ☐ other arthritic condition ☐ stroke ☐ anemia ☐ hepatitis

☐ kidney problem/infection ☐ liver problems ☐ bone or joint infection ☐ pneumonia

**Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?**

☐ cancer ☐ diabetes ☐ tuberculosis ☐ heart problems ☐ stroke ☐ thyroid problems

☐ high blood pressure ☐ depression ☐ blood clot(s)

**Have you ever taken steroid medications for any medical conditions?** ☐ Yes ☐ No

**Have you ever taken blood thinning or anticoagulant medications for any medical conditions?** ☐ Yes ☐ No

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**How & what date (roughly) did your problem (injury) start?**: _____

_____

**Please list any surgeries or other conditions for which you have been hospitalized, including dates:**

_____

_____

**Do you have a history of falls?:** ☐ Yes ☐ No; If yes please explain:_____

_____

**Easing Factors:** Identify up to 2 important positions or activities that make your symptoms better:

1. _____ 2. _____

**Aggravating Factors:** Identify up to 2 important activities that you are unable to do or are having difficulty with as a result of your problem.

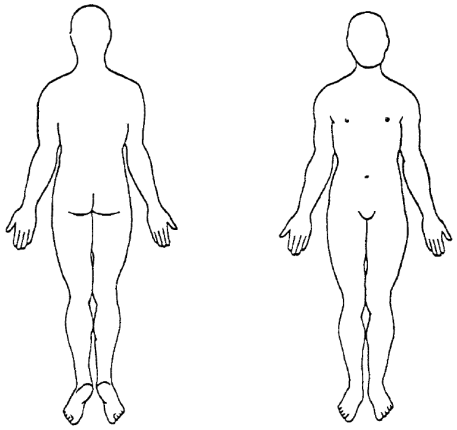
1. _____ 2. _____

**When are your symptoms worst?:** ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

**When are your symptoms the best?:** ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

| **Therapist Name:** | **Therapist Initials:** |
|---|---|
| | |

**Body Chart:**



Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

**My symptoms currently:** ☐ Getting Better ☐ Getting Worse ☐ Staying about the same
☐ Come and go ☐ Are Constant ☐ Are constant, but change with activity

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**Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:**

Circle your **current** level of pain while completing this survey: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **best** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **worst** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

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**BELOW FOR OFFICE USE ONLY**

***OBJECTIVE FINDINGS*** Discipline: (PT) / OT Involved Region: Left / Right / N/A

| **Strength (0-5)** Muscle | Grade | **Range of Motion** Motion | PROM | AROM |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Functional Deficits / Additional Information:**

✷ **= Pain**

**Work Related?** ☐ Yes ☐ No

**Specific Treatment Plan:**

**Treatment Goals:**

**Projected Frequency / Duration of Treatment:**

**Therapist Signature:**

**Printed Therapist Name and License #:**