MOVE BETTER
PHYSICAL THERAPY

PATIENT INFORMATION FORM

Name _____ Today's Date_____

Height _____ Weight_____ D.O.B._____ Age_____ Sex_____

Occupation_____ Name of referring physician:_____

Date of most recent examination: _____ Date of next appointment with referring physician:_____

Please list the names of other practitioners seen for this condition: _____

Please list all current medications:_____

MEDICAL HISTORY **Please circle if you have had or have any of the following:**

1) Heart Disease
2) Stroke
3) Respiratory Problems
4) Diabetes
5) Fainting
6) Allergies
7) Cancer
8) Changes in bowel/bladder habits
9) Numbness
10) Changes in sleeping pattern
11) Unexplained weight loss
12) Fever/Chills/Sweats
13) Weakness
14) Depression/Mental Illness
15) Dizziness
16) Night Pain
17) Shortness of Breath
18) Smoking and/or substance abuse

Please include additional information about circled items for clarification: _____

_____

Have you ever had surgery? If yes, please list all surgeries and dates: _____

_____

CONTRIBUTING FACTORS
Please circle one or more of the following problems if possibly relative to your present condition.

1) Injury 2) Heavy lifting 3) Unusual activity 4) Sustained or unusual posture

Please include additional information for clarification: _____

MEDICAL TESTING (related to your *current problem*)
If you have had any of the following tests, please provide the date performed and your interpretation of the results.

1) X-ray_____ 2) Electromyelogram_____ 3) Blood/Urine tests_____

4) MRI scan_____ 5) CT scan _____ 6) Other_____

A. NATURE OF SYMPTOMS

1) Chief complaint:_____

2) Severity of discomfort <u>at present time</u> (please rate by circling the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
No pain **Worst pain imaginable**

3) Onset

a. **WHEN did your pain begin (Please provide date)_____**
b. **Was the onset of your pain sudden_____ gradual_____ other_____?**
c. **WHERE and how did it begin (activity and specific cause) _____**
d. **Which of the following describes your problem?**
Worse_____ Better_____ Not Changing_____
e. **Have you received prior treatment for this condition?_____**

4) Description of discomfort:

ache_____ pain_____ sharp _____dull_____ pins and needles_____
numbness_____ tingling_____ burning_____ other_____

B. BEHAVIOR OF SYMPTOMS

1) Which of the following describes your discomfort? Constant_____ Intermittent_____

a. If intermittent, how often does it recur?_____

b. When it recurs, how long does it last?_____

c. How long can you be free of discomfort?_____

2) Describe your discomfort over a typical day (i.e. better/worse in the morning, noon, or night)

_____

3) What activities or positions aggravate your problem?_____

_____

4) Functionally, what activities are difficult to do because of your problem (i.e. vacuuming, brushing hair, climbing stairs, etc)_____

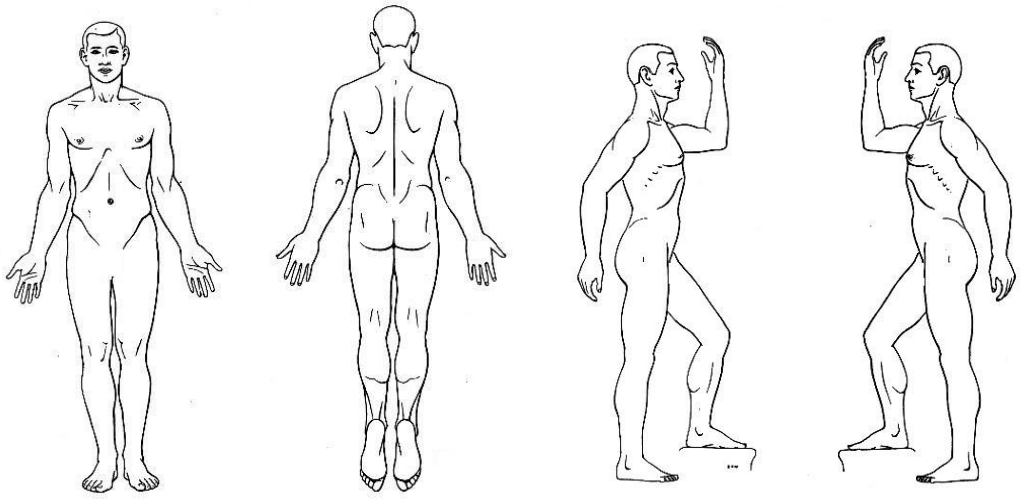
5) What activities or positions relieve your problem?_____

_____

6) What is the effect of rest on your discomfort?

Relieves_____ makes worse_____ no change_____ Does your discomfort ever wake you at night? _____

7) Present Location: Exactly where is your discomfort? Mark those areas on the body diagram that represent the location of your symptoms. √√√ Pain xxx Numbness



C. IS THERE ANYTHING ELSE RELATED TO YOUR PROBLEM THAT HAS NOT BEEN COVERED?_____

D. WHAT ARE YOUR GOALS? _____

E. DO YOU EXERCISE REGULARLY? YES / NO If yes, what is your primary activity?_____

_____

F. HAVE YOU HAD PREVIOUS PHYSICAL THERAPY? YES / NO If yes, where?_____

1. What was the outcome? _____