



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 at present time (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 _____

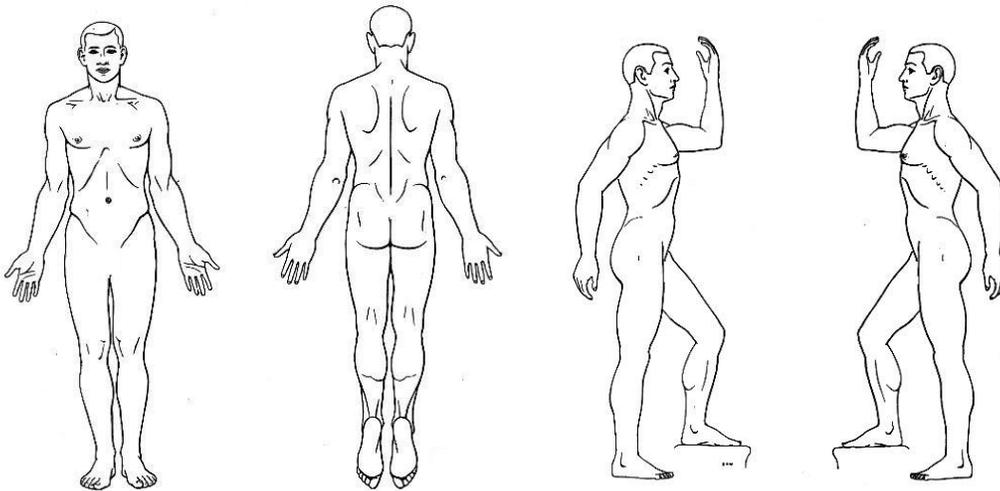
B. BEHAVIOR OF SYMPTOMS

- 1) Which of the following describes your discomfort? Constant _____ Intermittent _____
- If intermittent, how often does it recur? _____
 - When it recurs, how long does it last? _____
 - 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. $\checkmark\checkmark\checkmark$ 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? _____