

Name: _____ Date: _____ Primary Care Physician: _____

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

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> fever/chills/sweats |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pain at night |
| <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> headaches | <input type="checkbox"/> weakness/fatigue |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> changes in appetite | <input type="checkbox"/> difficulty swallowing |

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

- | | | |
|-----------------------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> cancer (type)_____ | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> stroke | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> kidney/liver problems |
| <input type="checkbox"/> asthma | <input type="checkbox"/> anemia | <input type="checkbox"/> stomach ulcers |
| <input type="checkbox"/> pacemaker inserted | <input type="checkbox"/> lung problems | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> other_____ | <input type="checkbox"/> other_____ |

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Do you smoke? **Yes No _____ pack/day**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications: _____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES: _____ **Are you latex sensitive? Yes No**

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

1. _____ 2. _____ 3. _____

Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

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

Pain Currently: Rate your level of pain at this time.

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

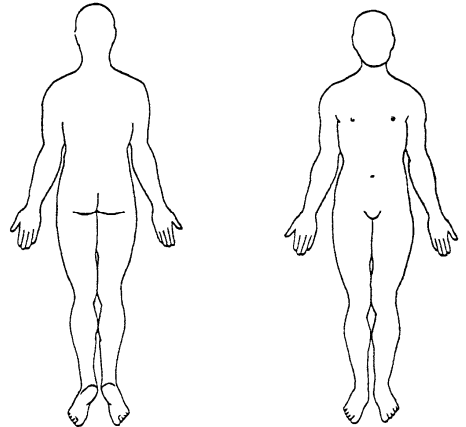
Pain at WORST: Rate your highest pain level in past 24 hrs.

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

Body Chart:

Please mark the location of your pain and type of pain on the chart:

- Key:
 X sharp stabbing pain
 O Dull achy pain
 ...Numb/Tingling
 /// Throbbing
 == Burning



List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. [Circle number below]:

_____ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10
 No pain Worst pain
 Imaginable

What is your goal for therapy at this time? _____

Patient Signature _____ **Date:** _____

(for office use only) PT initials _____ **Date** _____