

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

*This form will help us to have a better understanding of your unique situation and allow us to provide you with individualized, quality care. Please be as accurate as possible and if you are unable to answer any questions, we will discuss them during your appointment. Thank you.*

Background Information	Current Condition/Chief Complaint
1. Have you been here before? <b>Yes</b> or <b>No</b> 2. Sex: <b>Male</b> or <b>Female</b> 3. Hand dominance: <b>Right</b> or <b>Left</b> 4. Who referred you to physical therapy? _____ 5. Date of injury/surgery: _____	1. Briefly describe the problem for which you are seeking physical therapy: _____ 2. Where is your pain/problem? _____ 3. When did the problem begin? _____ 4. What caused your pain/problem? _____ 5. How would you like the physical therapist to help you today and over the course of treatment? _____
Pain Rating	Medications
1. Rate your pain on a 0-10 scale (0 is no pain, 10 is the worst you can imagine). Please <b>CIRCLE</b> . Pain right now: 0 1 2 3 4 5 6 7 8 9 10 Pain at best: 0 1 2 3 4 5 6 7 8 9 10 Pain at worst: 0 1 2 3 4 5 6 7 8 9 10 2. What aggravates you current problem? _____ 3. Is it getting: <b>Better/ Worse/ Staying the same?</b> 4. <b>CHECK</b> all that describe your pain/symptoms? <input type="checkbox"/> Burning <input type="checkbox"/> Snapping <input type="checkbox"/> Night Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Worse in AM/PM <input type="checkbox"/> Tingling <input type="checkbox"/> Dull <input type="checkbox"/> Other: _____ <input type="checkbox"/> Shooting <input type="checkbox"/> Sharp <input type="checkbox"/> Popping <input type="checkbox"/> Constant	1. Currently, are you taking any medications? _____ 2. Are you taking any medication for this problem? <b>Yes</b> or <b>No</b> If yes, what and does it help? _____ 3. Currently, are you taking vitamins/supplements? <b>Yes</b> or <b>No</b> If yes, please list: _____
Occupation	Social Health
1. Who is your employer? _____ 2. What is your job title? _____ 3. Are you currently working? <b>Yes</b> or <b>No</b> If yes, list restrictions: _____ 4. Is this a work comp injury? <b>Yes</b> or <b>No</b> 5. Is your job physically demanding? <b>Yes</b> or <b>No</b> 6. Are there lifting requirements? <b>Yes</b> or <b>No</b> If yes, list restrictions: _____	1. What is your current health? Please <b>CHECK</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor 2. Currently, do you smoke tobacco? <b>Yes</b> or <b>No</b> If yes, how many packs/cigars/pipes per week? _____ 3. Currently, do you consume alcohol? <b>Yes</b> or <b>No</b> If yes, what is the average amount consumed per week? _____ 4. Currently, do you exercise beyond normal activities? <b>Yes</b> or <b>No</b> If yes, describe the exercise and how often per week? _____
Medical History (Past and Current)	
1. Please <b>CHECK</b> all of the following that apply: <input type="checkbox"/> Persistent pain at night <input type="checkbox"/> Persistent cough <input type="checkbox"/> Constant pain anywhere in body <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unusual lumps or growth <input type="checkbox"/> Unwarranted fatigue <input type="checkbox"/> Tumors <input type="checkbox"/> Fever or night sweats  <input type="checkbox"/> Recent severe emotional disturbances <input type="checkbox"/> Increase in stress or loss of motivation <input type="checkbox"/> Swelling or redness in joint <input type="checkbox"/> Pregnancy <input type="checkbox"/> Recent infections <input type="checkbox"/> Recent fractures <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Prolonged steroid use <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid conditions <input type="checkbox"/> Metabolic disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Implantable devices	<input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dizziness <input type="checkbox"/> Pain or a feeling of heaviness in the chest <input type="checkbox"/> Pulsating pain anywhere in the body <input type="checkbox"/> Constant and severe pain in lower leg or arm <input type="checkbox"/> Discolored or painful feet <input type="checkbox"/> Swelling <input type="checkbox"/> Blood clot issues  <input type="checkbox"/> Food allergies/sensitivities <input type="checkbox"/> Frequent or severe abdominal pain <input type="checkbox"/> Frequent heartburn/indigestion <input type="checkbox"/> Frequent nausea or vomiting <input type="checkbox"/> Change in or problems with bladder function i.e. UTI <input type="checkbox"/> Unusual menstrual irregularities  <input type="checkbox"/> Changes in hearing <input type="checkbox"/> Frequent or severe headaches <input type="checkbox"/> Problems with swallowing or changes in speech <input type="checkbox"/> Changes in vision <input type="checkbox"/> Problems with balance, coordination or falling <input type="checkbox"/> Faint spells <input type="checkbox"/> Sudden weakness

**\*\*To be completed by your physical therapist\*\***

## SCREENING

**S/Hx:**

**O:**

**A:**

**P:**

- Recommend/refer to: ER / MD / Surgical Consult / Needs additional diagnostic testing / Other: \_\_\_\_\_
- PT:
  - Recommend: \_\_\_\_\_ x per week for \_\_\_\_\_ weeks
  - Recommended treatments:
  - Home treatment, see instructions below

## TREATMENT AND INSTRUCTIONS PROVIDED

**Yes / No:** Screened for CI's prior to treatment or instruction, list:

- Ice 5x/day x 2-3 days and repeat if causes new pain or more pain
- Cause no pain
- Rest, limit painful or athletic activity for \_\_\_\_\_ (duration)
- 830nm Low Level Laser x \_\_\_\_\_ J/cm<sup>2</sup> to the \_\_\_\_\_
  - Pretest:
  - Post-test:
- Therapeutic Exercises recommended:

Results of treatment:

**Physical Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Circle One) Kim Gordon, MPT   Kristina Kurtz, DPT   Brian McQuilkin, DPT   Joan Ward, MSPT