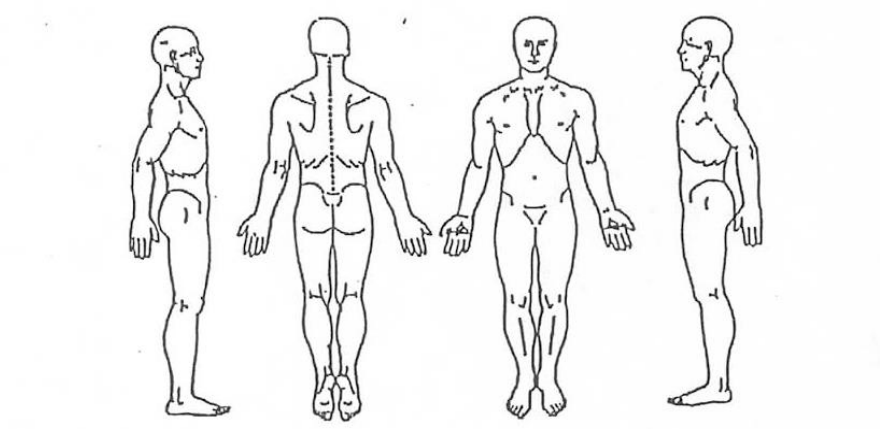
Name: _____ Age: _____ Date: _____

Body Part: _____ Date of Injury: _____ Date of Surgery: _____

Occupation: _____

Work Status: □ Regular □ Light Duty □ Not working due to this problem □ Retired □ Other

Mark on picture where you have symptoms:



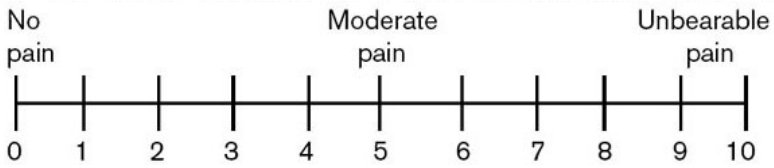
Type of Pain: □ Sharp □ Dull □ Burning □ Numbness/Tingling □ Stiffness □ Other

The Pain is: □ Constant □ Intermittent (comes and goes)

What make symptoms better? _____

What make symptoms worse? _____

Please rate the intensity of your pain on average in the last 24 hours:



Have you had Physical Therapy in any facility, including home health PT, for any body part within the past year? YES or NO If yes, how many visits? _____ Name of facility: _____

Medical History- Please check any boxes that apply:

Heart Problems		Epilepsy	
Pacemaker		Kidney Problems	
Heart Attack		TMJ	
High/ Low Blood Pressure		Arthritis	
Cancer		Headaches	
Diabetes		Dizziness	
Osteoporosis		Hypoglycemia	
Asthma/Lung Disease		Difficulty Swallowing	
Infectious Disease		Latex Allergy	
Back or Neck Problems		Alcohol/ Drug Problems	
Have you ever been pregnant?		Smoking	
Are you currently pregnant?		Other	

Other Medical History: _____

Major Surgeries: _____

Emergency Contact: _____ Number: _____