1. What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you presently working? **Yes No**

2. What brings you to **Physical Therapy** today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please circle involved side:** Right Left

3. When did this problem begin? Date of Injury : \_\_\_\_\_

4. How did this injury / exacerbation occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Where did this occur? ie: home, work, athletic field, auto accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Please rate your pain severity using the following scale:

Least Severe 1 2 3 4 5 6 7 8 9 10 Most severe

7. Have you had any **special tests** for this problem? **Yes No**

 **a.) X-rays Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **b.) MRI Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **c.) Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

8. Have you had this problem in the past? **Yes No**

 **If Yes, when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What prior treatment have you had for this problem? (ie: PT, Chiropractic, Injections):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it helpful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Please describe any **surgeries** that you have had:

 Orthopedic: Date of surgery:

 Heart / General : Date of surgery:

11. Please circle any of the over-the-counter or prescription medications you are currently taking:

 Anti-inflammatory Cardiac Medications Muscle relaxants

 Anti-seizure medication Steroid medication Heparin / Coumadin

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Please circle all of the following conditions that apply to your **current or past medical history**:

 Currently Pregnant Unexplained Weight Loss Pacemaker

Rheumatoid Arthritis High Blood Pressure Kidney Disease

 Heart Problems Multiple Sclerosis Cancer

 Osteoporosis Stroke Anemia

 Hepatitis Mental Illness Asthma

 Diabetes Emphysema Seizures

 Chemical Dependency Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. What **goals** do you hope to achieve during your care here?