Name: _____

DOB: _____

Date: _____

ENCORE PHYSICAL THERAPY

Returning patients only: Review and update (initial and date): _____

To evaluate your condition fully, please complete the questions as accurately as possible. Thank you!

1. What is your primary complaint that brings you here? _____
2. When did your symptoms begin or worsen (date)?_____
3. Have you had surgery for this injury? Yes No If yes, when?_____
4. What caused your symptoms to begin or injury to occur? _____

_____

5. Currently, are any of your daily or recreational activities affected? Yes No If yes, how?_____

_____

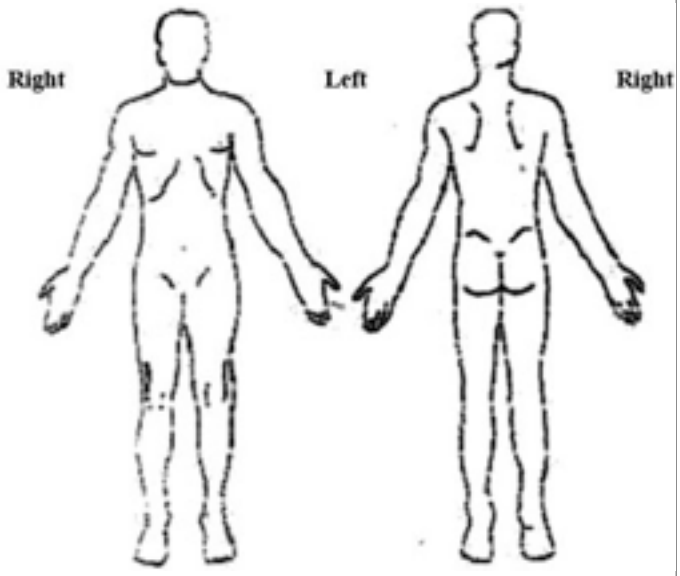
6. What makes your symptoms worse (positions/activities/time of day)? _____

_____

7. What improves your symptoms? _____
8. **Prior to onset of your symptoms**:
   Did you have any limitations with activities, or require physical assistance? Yes No
   If yes, please explain: _____
   Were you physically active on a regular basis? Yes No
   If yes, list primary activities: _____ How often? _____
9. Have you had these symptoms before? Yes No
   a. If yes, did you receive any treatment? Yes No Did the treatment help? Yes No

   What did the treatment consist of? _____
10. What are your **goals for physical therapy**? (pain, activities, movement, preparation for event, etc.)

_____

11. Where is your pain? Please draw on body diagram	12. Please rate and describe your pain
	 <u>Please rate your pain on a scale of 0-10</u> Worst pain in last week: /10 Current pain: /10 At best: /10 <u>My symptoms bother me:</u> • Constantly • Most of the time • Occasionally <u>My pain is (circle all that apply):</u> Sharp Stabbing Shooting Throbbing Burning Aching Other_____ <u>My pain is getting:</u> Better Worse Staying the same

Name: _____ **DOB:** _____

13. Past Medical History (circle all that apply):

Diabetes Type I or II	Epilepsy/Seizures	Depression
Current smoker	Balance disorder/Vertigo	Anxiety
Former smoker	Chronic Headaches/Migraines	Pregnant or possibly pregnant
Hepatitis A B C	TMJ disorders	Gynecological disorders
Lung problems	Head injury	Thyroid problems - hypo or hyper
High Blood Pressure	Stroke	Fibromyalgia
High Cholesterol	Circulation/Vascular problems	Chronic Fatigue Syndrome
Chest pain/Angina	Bleeding/bruising	Osteoporosis
Pacemaker	Blood disorders	Arthritis/joint pain
Anemia	Spinal Cord Injury	Hernia
Lightheadedness/dizziness	Polio/muscle disease	Kidney Disease
Hypoglycemia	Lyme's Disease	Fainting Disorders

Cardiac/Heart Condition: (describe) _____

Respiratory Problems: (describe) _____

Fractures (describe): _____

Cancer: (describe) _____

Any other chronic illnesses or conditions?

_____

14. **List surgeries / major injuries and dates** for which you have been treated, including fractures, dislocations, joint replacements, etc. (continue on lower margin if more space is needed)

_____

_____

15. Currently, I am experiencing (circle all that apply):

Numbness/Tingling	Headaches	Unexplained weight change
Depression/Anxiety	Changes in appetite	Poor balance/dizziness
Difficulty swallowing	Weakness	Pain that worsens at night
Fever/Chills/Sweats	Swelling	Changes in bowel/bladder function
Nausea/Vomiting	Shortness of breath	Loss of motion

16. Have you had **diagnostic tests** for this problem? (x-ray, MRI, CT scan, Bone Scan, Ultrasound, lab tests)
If so, what were the results? _____

17. **List medications** you are currently taking (including pills, injections, and/or skin patches). **MEDICARE only:** Please list medications, dosages as well as frequency. If you have a medication list with all the necessary info, we will make a copy.

_____

_____

18. What is your current weight? _____lbs 19. What is your current height? _____ feet _____ inches

20. What does your blood pressure normally run at? _____ Systolic (top #) _____ Diastolic (lower #)

18. **List allergies**: _____

Patient Signature:_____ **Date:**_____

Relationship is other than patient/ Parent / Guardian if minor: _____

This information will be used as a guide in your treatment plan. If you need any medical follow-up, please contact your physician.