How did you hear about our services? _____

Please check if you have or have had any of the following:

- ❑ Diabetes
- ❑ Heart Attack
- ❑ Cancer_____
- ❑ Osteoporosis/Osteopenia
- ❑ Shortness of Breath
- ❑ Broken bones _____
- ❑ Lung Disease
- ❑ Circulatory/Vascular Problems
- ❑ Neurological Problems
- ❑ High Blood Pressure
- ❑ Stroke/TIAs
- ❑ Dizziness
- ❑ Headaches
- ❑ Head Injury
- ❑ Mental or Emotional disorders/difficulties
- ❑ Substance Abuse (current or in recovery)
- ❑ Arthritis
- ❑ Bleeding/Bruising Tendency
- ❑ Car Accident
- ❑ Falls
- ❑ Other _____ _____

Please list, with approximate date, all accidents, surgeries (including cosmetic/reconstructive) and hospitalizations: _____

_____

_____

Please list all your current medications, supplements, and homeopathic treatments: _____

_____

_____

What are the main reasons you are seeking Physical Therapy? _____

_____

Have you had any treatment for the problem which brings you here today? Yes _____ No _____
If "yes," please describe_____

Have you had any physical or speech therapy this year? Yes _____ No _____ If yes, please explain:

_____

When did your symptoms begin? _____

Was the onset sudden, due to an accident/activity or was the onset gradual? _____

_____

What activities make your symptoms worse? _____

_____

What makes your symptoms better? _____

_____

What results do you want from Physical Therapy? _____

_____

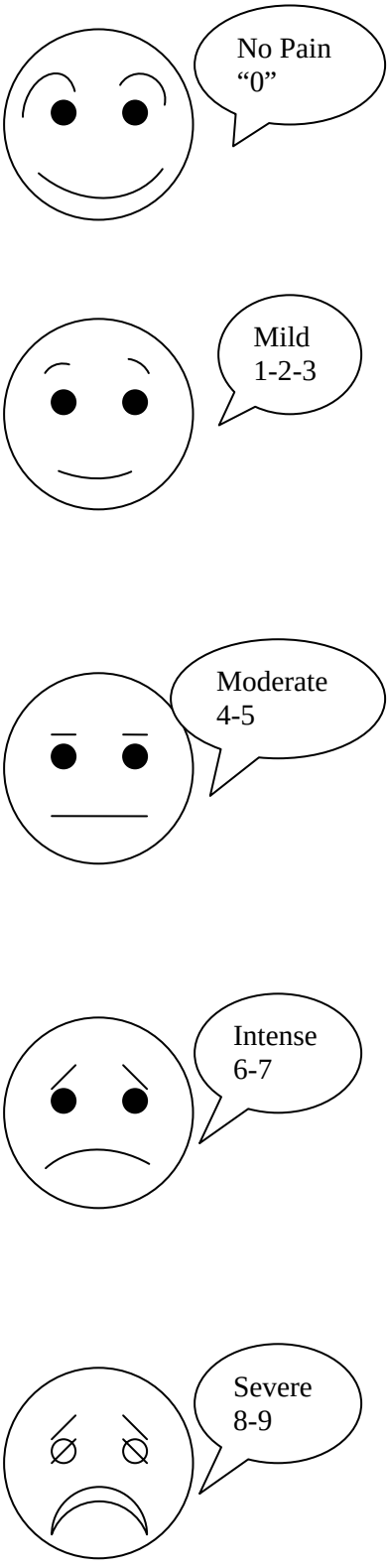
What are you currently doing for self-care of your problem? _____

_____

Patient name: _____ Date: _____

"0-9" Pain Scale

Please use the following information when rating your pain and answering questions regarding your condition.



No Pain: Feeling perfectly normal. Rate this as "0".

Mild Pain: Pain does not interfere with most activities. You are able to adapt to the pain psychologically and with medication or devices such as cushions.

1... Vague Discomfort: Very light, barely noticeable pain, like a mosquito bite or poison ivy itch.

2... Mild but Discomforting: Minor pain, like lightly pinching the fold of skin between the thumb and first finger with the other hand, using the fingernails. Note that people react differently to this self-test.

3... Uncomfortable but Tolerable: Very noticeable pain, like an accidental cut, or a doctor giving you an injection. The pain is not so strong that you cannot get used to it. Eventually, most of the time, you don't notice the pain, because you have adapted to it.

Moderate Pain: Pain interferes with many activities. Requires lifestyle changes but you remain independent and functional. You are unable to adapt to this pain.

4... Annoying: Strong, deep pain, like an average toothache, the initial pain from a bee sting, or minor trauma to part of the body, such as stubbing your toe. Pain is strong enough that you notice it all the time and you cannot completely adapt to it. Initially piercing, the pain becomes dull after that.

5... Very Uncomfortable: The pain is noticeable all the time, and you are now preoccupied with managing the pain, curtailing your normal lifestyle.

Intense Pain: Pain interferes with your job or normal interactions. You require some assistance to function.

6... Distressing or Intense: The pain is now strong enough to dominate your senses and cause you to think somewhat unclearly, making it hard for you to do your job or maintain normal social interactions.

7... Very Intense: The pain completely dominates your senses and causes you to think unclearly about half the time. At this point you are effectively disabled and frequently cannot live alone.

Severe: You are unable to engage in normal activities. You find yourself disabled and unable to function independently.

8... Excruciating: Pain is so intense, that you can no longer think clearly at all. There is no more joy in life, whatsoever, due to the intensity of your pain. You demand painkillers or surgery, no matter what the side effects or risks. You may have even considered suicide.

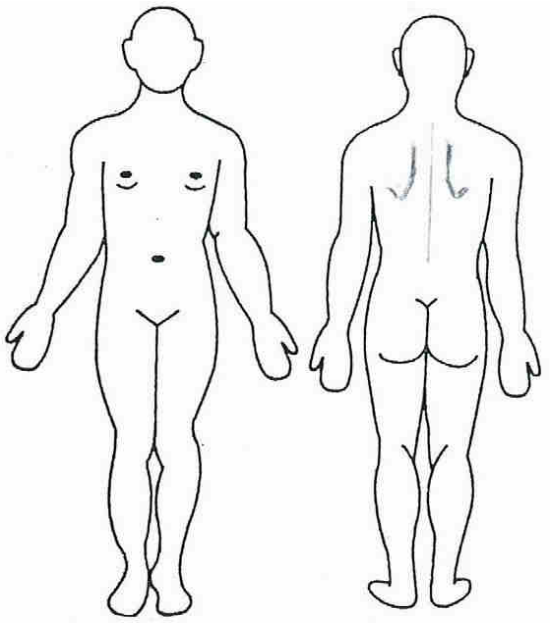
9... Intolerable or Unbearable: Pain is so intense that you feel like you are going to pass out. You would go to the emergency room with this type of pain.

Patient name: _____ Date: _____

Please indicate on the scale below, the intensity of your symptoms:

0	1	2	3	4	5	6	7	8	9
none		mild		very uncomfortable		distressing		severe	intolerable

Please indicate on the figures the area(s) in which you are experiencing symptoms:



Also, please list your most painful areas and rate them using the 0-9 scale above:

Area (1) _____
Usual pain level:
Lowest level:
Highest level:
% of time at highest pain level: ___

Area (2) _____
Usual pain level:
Lowest level:
Highest level:
% of time at highest pain level: ___

Area (3) _____
Usual pain level:
Lowest level:
Highest level:
% of time at highest pain level: ___

Now, using a 0-9 scale where "9" is the highest or <u>most positive</u> rating and "0" is the lowest rating, please rate each of the following.

1. Health _____
2. Well-being _____
3. Energy level _____
4. Freedom from Tension _____
5. Knowledge of your body _____
6. Ability to deal with stress _____
7. Freedom from pain _____

What was your last recorded height? _____

(for Physical Therapist: today's height: _____)

Thank you *for providing this information for us. It will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you.*

Please look over your Initial Questionnaire form carefully. It is important that you inform us of ***<u>ALL</u>*** *medical/health conditions at your first appointment, and immediately inform us of any changes in your medical/health condition during your course of treatment.*

Patients who intentionally withhold pertinent medical/health information from their Physical Therapist may be dismissed from treatment, at the Physical Therapist's discretion.

Patient name: _____ Date: _____