

Name: _____

DOB: _____

Dear Patient: Please provide us with this important health history information. If you do not understand a question, your therapist will assist you. Thank you.

1. For what condition are you seeking treatment here? _____

2. Date of onset of condition? _____ Date of Surgery? _____

3. Cause of Condition? _____ Did this happen at work? Yes No

4. What are your symptoms? Pain Weakness Numbness Tingling Motion Loss
 Difficulty walking Dizziness Nausea Poor Balance Other _____

5. Are your symptoms getting: Better Same Worse
 Pain is: Constant Intermittent Varies
 Can you describe your pain? (Ex: burning, sharp) _____

6. Time of day pain is worse: Mornings Evenings As day progresses Sleep disturbed

7. Pain is better with: Heat Ice Medication Rest Position No relief Other _____

8. Have you had any diagnostic tests? X-ray MRI CT Scan Dexascan None Other _____

9. Occupation: _____ Physical Demands of job: Heavy lifting Repetitive movements
 Overhead lifting Sitting Standing Computer work Phone Driving Up/Down from chair

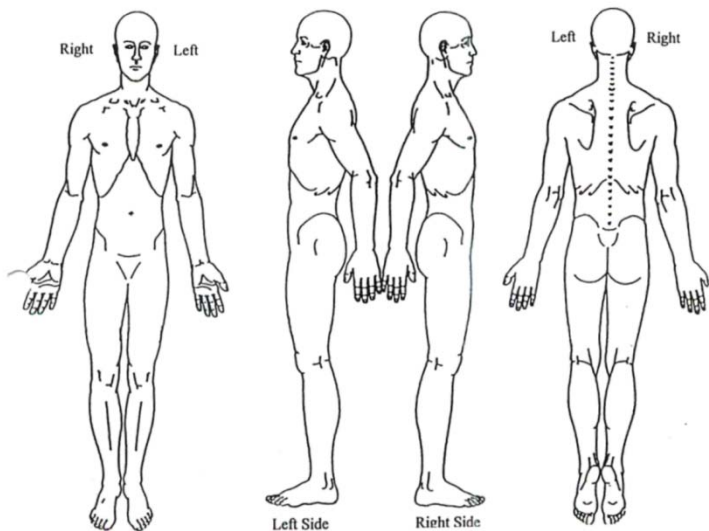
10. Previous Treatments: None Physical Therapy Medication Chiropractor/DO Injection
 Other _____

11. Please list your medications:

11. Which activities are limited? Home / Daily living Work Recreation/Exercise Sport

12. What are your goals for therapy? Reduce pain Increase motion Increase Strength Return to work
 Home Education program

13. Please mark areas of pain on the diagram below



Patient Signature: _____

Date: _____