

Patient Name _____ Date _____

What is the current problem for which you were referred? _____

What is your current occupation? _____

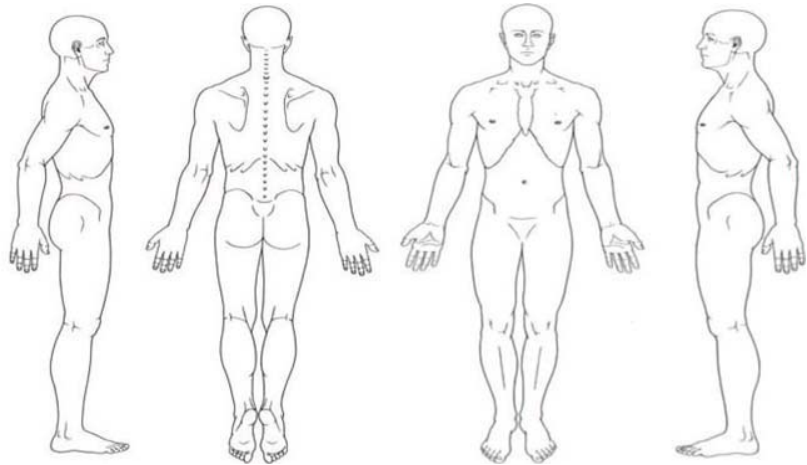
Date of next doctor appointment: _____ When did your symptoms start? _____

How did your symptoms begin? _____

Please indicate on the body views, where you have pain and or other symptoms.

**PLEASE MARK ON BODY
DIAGRAM WITH /// OR XXX
WHERE EACH SYMPTOM IS
LOCATED.**

PAIN ///
PINS & NEEDLES XXXX



Please list all medications you are presently taking. _____

Please complete the following information regarding any special tests you have had done for this condition.

MRI X-ray CAT SCAN other _____ Date completed _____

Have you had any of the following this year?

Physical therapy ____ Occupational therapy ____ Speech therapy ____ Chiropractic care ____ Home care ____

If yes, where were you treated and for what condition?

Allergies (medications, environmental, tape, lotions, latex, food, other) _____

Arthritis: Where? _____ Stroke: When? _____

Recent or major surgeries _____

Past or Present Medical History

____ Cancer / Type _____
 ____ Joint Implants _____
 ____ Fractures _____
 ____ High Blood Pressure _____
 ____ Are you currently pregnant? _____

____ Headaches _____
 ____ Diabetes _____
 ____ Open Wounds _____
 ____ Cardiac Problems(describe below) _____

____ Vision/Hearing Problems _____
 ____ History of HIV/Hepatitis _____
 ____ Pacemaker _____
 ____ Skin Problems _____
 ____ Asthma _____

Other medical conditions _____

What goals do you hope to accomplish with your physical therapy? _____

Patient's signature _____ Therapist's signature _____