Print Name: _____ Birth Date: _____

Have you ever had the following conditions? (Please check)

Condition	Yes	No
Heart trouble		
High blood pressure		
Diabetes		
Headaches		
Dizzy spells		
Fainting spells		
Epilepsy		
Stroke		
Pregnant		

Condition	Yes	No
Asthma		
Emphysema		
Back injury		
Arthritis		
Bleeding disorder		
Fracture		
Cancer		
Pacemaker		
Other:		

Regarding your present injury / condition:

Date of injury / condition: _____

How did the injury occur? _____

Have you been hospitalized for the present problem? Yes No

Have you had surgery for the present problem? Yes No

Have you had therapy for current problem? Yes No If so, please summarize the results: _____

Last seen by physician for present problem on _____ (date) Next appointment scheduled on _____ (date)

Are you being seen by any other physician? Yes No _____

Allergies Yes No If yes, list _____

Are you on medication: Yes No If yes, list type of medication (including over-the-counter medications, herbal supplements and vitamins): _____

Which of the following best describes your symptoms (check those that are appropriate)?

Sharp Dull Burning Numbness

Constant Intermittent Pins and needles

Other: _____

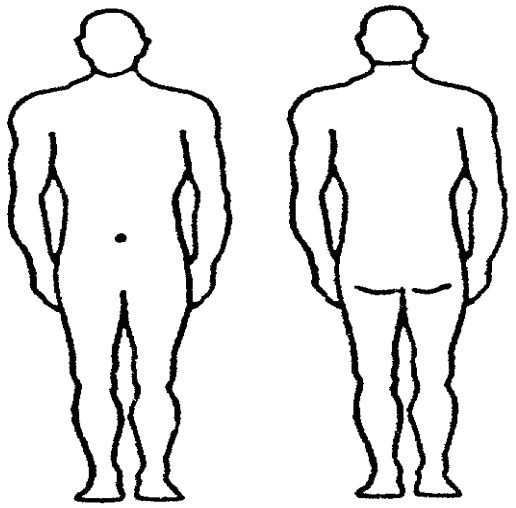
Using a scale of 0 – 10, please rate your pain (0 being no pain, 10 being the most pain):_____

What are the goals you would like to achieve through therapy?

_____

_____

On the figures below, please shade in your painful area:



Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

LABEL:

REHABILITATIVE SERVICES – PAST MEDICAL HISTORY