

Name: _____

Date: _____



Physical Therapy & Rehab Specialists

Rice Lake • Turtle Lake • Clear Lake • Spooner • Hayward

Please check the following conditions as they apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Parkinsons |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | | |

1. Height: _____ Weight: _____

2. Are you currently taking any medications? Y / N

If yes, please list dosage and reason for taking: _____

3. Have you had any past surgical procedures? Y / N

If yes, please list and include month and year: _____

4. Are you currently pregnant? Y / N Or have you been in the last year? Y / N

5. Do you smoke? Y / N Do you drink alcohol? Y / N

6. Have you received physical therapy previously? Y / N

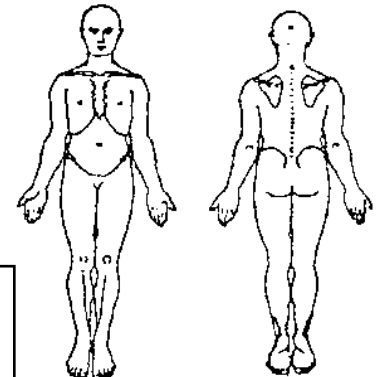
7. Is this work related? Y / N Is this related to an auto accident? Y / N

8. Please describe your injury and location of pain: _____

9. How and when did it start?: _____

10. Does your current problem interfere with any of the following?:

- | | | |
|--|---|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Walking | <input type="checkbox"/> Reaching overhead |
| <input type="checkbox"/> Combing your hair | <input type="checkbox"/> Lifting a gallon of milk | <input type="checkbox"/> Writing a letter |
| <input type="checkbox"/> Bending over | <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Driving | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Putting on shoes | <input type="checkbox"/> _____ |



Please circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10

0 Being NO pain

10 go to emergency room