

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

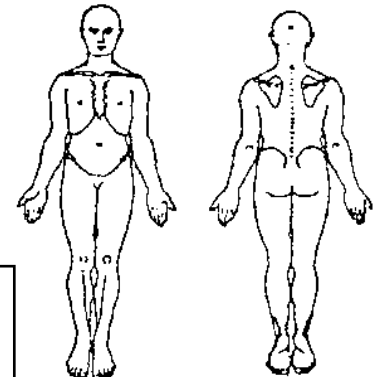
7. Is this work related? Y / N Is this related to an auto accident? Y / N

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