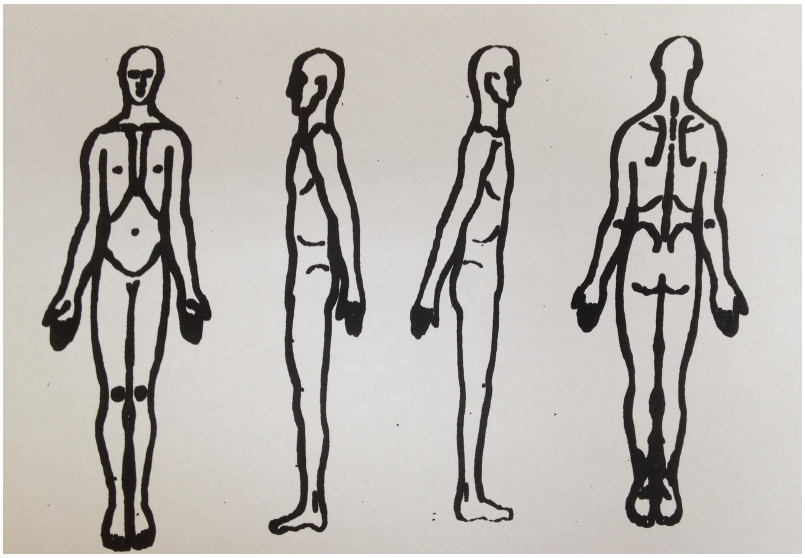
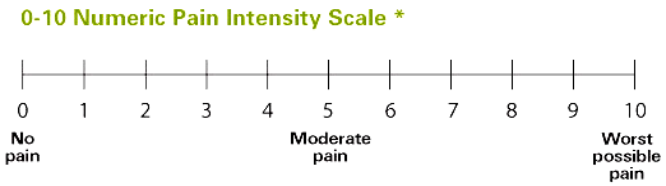
NAME: _____ DATE: _____

Circle ALL problem areas on the body pictures.



Please mark on the scale below your pain intensity.



Is this related to accident: ____Yes ____No

If yes, list details & date:

1. Why are you here? Chief complaint(s):

2. Current Level of Function. Describe any functional limitations/impairments that affect your daily life?
   Examples: Can't sit longer than _____ minutes or ____ hours
   Can't stand longer than _____minutes or ____ hours
   Can't walk longer than _____minutes or _____hours
   Walking outdoors _____
   Can't sleep longer than _____minutes or _____hours
   Balance abilities/deficits_____
   Bending/Stooping _____
   Lifting _____
   Bed mobility/transfers _____
   Laying flat_____
   Ambulation _____
   Stair/Steps climbing _____
   Transfers (to auto/commode/chair) _____
   Moving (lying to sitting/sit to stand/rolling over)_____
   Driving/Neck rotation_____
   Household chores/cooking/cleaning/laundry_____
   Pushing or Pulling _____
   Carrying _____
   Abdominal issues: _____
   Bathing/Grooming_____
   Dressing _____
   Other_____
   _____
   _____

3. Prior Level of Function. What were you able to do that you cannot do now or it is done with difficulty?

4: Onset of complaint or how long have you had these symptoms?

5. What are your goals? What are you trying to accomplish?

6. Any Previous Physical Therapy: ____Yes ____No
If Yes, approximate number of visits: ____ approx. dates: _____ for what diagnosis_____

7. Medical history – Surgeries with Date:

8. Medical history – Other conditions/diseases with date of diagnosis:

9. Females - List each birth by date and if vaginal or C-Section:

10. Current prescription, supplements and over-the-counter medications. List what each medication is for.

11. Major car accidents or broken bones with date of occurrence:

12. What treatment has been done by physician for this condition? (Surgery/medication changes/ therapy, etc.)

13. Relevant diagnostic tests & results

14. Do you use any assistive device? (walker/cane/brace)

15. Currently, where do you live? (your own home, with family member, assisted living facility)

16. Currently, who do you live with or do you live alone?

17. Any other information we should be aware of?