PHYSICAL THERAPY & SPORTS MEDICINE CENTERS

PT for life A PTSMC affiliate

Name: _____ **Primary Care Physician:**_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in appetite
- ❑ changes in bowel or bladder function
- ❑ difficulty maintaining balance while walking
- ❑ difficulty swallowing
- ❑ dizziness/lightheadedness
- ❑ fever/chills/sweats
- ❑ headaches
- ❑ nausea/vomiting
- ❑ pain at night
- ❑ shortness of breath
- ❑ weakness/fatigue
- ❑ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ anemia
- ❑ asthma
- ❑ cancer (type)_____
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ diabetes Check One: ☐ Type 1 ☐ Type 2
- ❑ epilepsy
- ❑ heart disease
- ❑ high blood pressure
- ❑ kidney/liver problems
- ❑ lung problems
- ❑ multiple sclerosis
- ❑ osteoporosis
- ❑ pacemaker inserted
- ❑ Parkinson's disease
- ❑ rheumatoid arthritis
- ❑ stomach ulcers
- ❑ stroke
- ❑ thyroid problems
- ❑ other_____
- ❑ other_____

During the past month have you been feeling down, depressed or hopeless? ☐ **YES** ☐ **NO**
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ **YES** ☐ **NO**
Is this something with which you would like help? ☐ **YES** ☐ **YES, but not today** ☐ **NO**

Do you smoke? ☐ **YES** ☐ **NO** _____ **pack/day**

Height:_____ **Weight:** _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ **YES** ☐ **NO**

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? ☐ **YES** ☐ **NO**

ALLERGIES: _____
Are you latex sensitive? ☐ **YES** ☐ **NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

For the injury you are seeing us for today:

Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain now.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

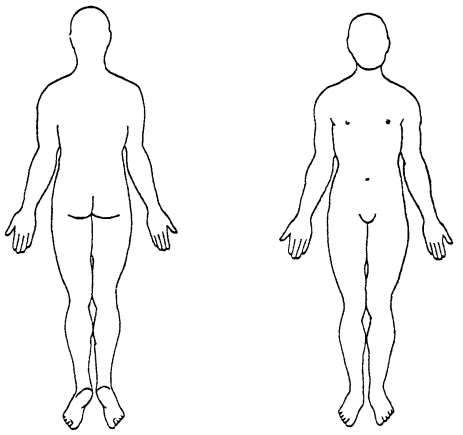
Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



What is your goal for therapy at this time?_____

Patient/Guardian/Responsible Party Signature:_____ **Date:**_____