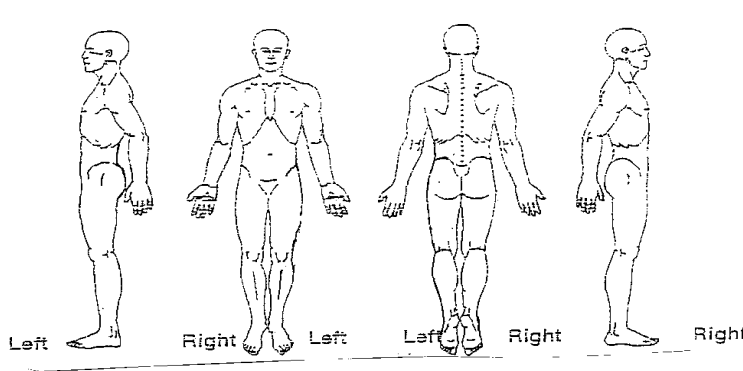


1. What condition brings you to therapy? _____
2. Start date of condition or date of injury or surgery _____
3. What diagnostic tests (x-ray, MRI, EMG etc.) have you had for this condition?

4. What recent treatments (therapy, medication, chiropractor, injections, surgery, etc.) have you had for this condition? _____
5. Have you had this condition before? How was it treated and was it helpful? _____
6. When are you scheduled to see the doctor again? _____
7. Are you presently employed? Yes: Full-Time Part-Time
 No: Retired Disabled Other: _____
8. What is/was your occupation? _____
9. Is your condition the result of a workplace injury? No Yes
10. Please list any activity restrictions that your doctor has given you (sling, lifting, weight bearing, etc.):

11. What are your hobbies/recreational interests? _____
12. Do you exercise? No Yes Frequency/Type: _____
13. Do you currently have any stressful (personal, job, family etc.) concerns in your life?
 No Yes: _____
14. Is someone currently helping your perform your daily tasks? No Yes: Who helps and how does she/he help? _____
15. What are your goals for therapy? _____
16. If you have pain or other symptoms, mark the areas on the diagram and circle your rating below:

	10		
	9		
	8		Worst Possible
	7		
	6		Very Severe
	5		
	4		Severe
	3		
	2		Moderate
	1		Mild
	0		No Symptoms



17. Please identify 2 – 3 activities that you are unable or are have difficulty performing due to your current condition. Please use the scale below to rate your ability to do these activities.

Please circle one number that best rates your ability to do each activity that you list.

0= Unable to perform activity

10=Able to perform activity
at level before injury

Activity # 1: _____

0 1 2 3 4 5 6 7 8 9 10

Activity # 2: _____

0 1 2 3 4 5 6 7 8 9 10

Activity # 3: _____

0 1 2 3 4 5 6 7 8 9 10

18. Please check/list any health conditions that you currently have or have had in the past:

- Surgeries (When/Type): _____
- Broken Bone(s): _____
- Cancer (When/Type): _____
- Allergies: _____
- Heart Problems: _____
- High/Low Blood Pressure (Circle One)
- Diabetes
- Stroke
- Circulatory Problems
- Chronic Infections: _____
- Lung Problems/Asthma
- Rheumatoid Arthritis
- Osteoarthritis
- Osteoporosis
- Epilepsy/Seizures
- Depression
- Mental Health Condition: _____
- Chemical Dependency: (ie. caffeine, nicotine, alcohol, drugs) _____
- Bowel Incontinence
- Bladder Incontinence
- Pregnancy: # _____ Due date: _____
- Other Condition(s): _____

19. Please list all prescription and over the counter medications with the reason for taking.

Patient Signature: _____ Date: _____