Agape Physical Therapy
Serving Our Community In Love

Patient Name _____
Date_____

Gender ☐ M ☐ F **Age** _____ **Smoker** ☐ Yes ☐ No ☐ Quit

What tests have you had for your symptoms and when were they performed?

☐ X rays
date:_____

☐ CT Scan
date:_____

☐ MRI
date:_____

☐ Other
date:_____

Current Symptoms:

_____

ONSET: The date of my injury/ accident OR onset of problem was (date):

_____

CAUSE: My symptoms started: ☐ Suddenly ☐ Gradually and likely began because (details):

_____

_____

_____

My symptoms are currently: ☐ Getting better ☐ About the same ☐ Getting worse

Aggravating factors: This makes my pain worse:

1. _____ **2.** _____ **3.** _____

Easing factors: This makes my pain Better:

1. _____ **2.** _____ **3.** _____

Please circle the number below which best represents your average pain level in the previous 24 hours

Cannot do Anything **0 1 2 3 4 5 6 7 8 9 10** able to do everything

- Do you have difficulty swallowing? ☐ Yes ☐ No
- Does coughing, sneezing or taking a deep breath aggravate your symptoms? ☐ Yes ☐ No
- Does bending sitting, lifting or twisting your back aggravate your symptoms? ☐ Yes ☐ No
- Has there been any change in bowel habit since onset of your symptoms? ☐ Yes ☐ No
- Does eating certain foods aggravate your symptoms? ☐ Yes ☐ No
- Has there been any weight change since onset of symptoms? ☐ Yes ☐ No

TREATMENT: Treatment of my problem to date has included /currently includes (surgery, PT, chiropractic work):

_____

_____

Have you ever had this problem before? ☐ Yes ☐ No

If so, how was the problem treated?

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How long did it take for you to get better? _____

YOUR GOALS: (what do you want PT to help you with? (*e.g. return to running*):_____

_____

I have been treated at **Agape P.T.** before (*details*): ☐ No ☐ Yes for _____

MEDICATIONS: (*Please mark the appropriate lines with and **X** and provide details*)

____ I am taking 'over the counter' anti-inflammatory, pain meds, or muscle relaxant _____

____ I am taking prescription anti-inflammatory, pain meds, or muscle relaxants _____

____ I am taking other medications _____

_____

PROBLEMS: (*check and provide details*)	MILD	MODERATE	SEVERE
Swelling	_____	_____	_____
Headaches	_____	_____	_____
Numbness/Abnormal sensation	_____	_____	_____
Loss of function (any type of normal activities)	_____	_____	_____
Loss of strength	_____	_____	_____
Loss of flexibility	_____	_____	_____
Loss of sleep	_____	_____	_____
Loss of balance (e.g., standing on 1 leg)	_____	_____	_____
Loss of bowel/bladder function	_____	_____	_____

Other Problem/Loss _____

SPECIAL QUESTIONS (*Please mark the appropriate lines with an **X**, and provide details*)

_____ I am taking blood thinners: Yes NO

_____ I am allergic to latex: Yes NO

_____ I am pregnant or think I might be pregnant _____

_____ I have a pacemaker, surgical hardware or other implanted device _____

_____ I have weight-bearing restrictions given to me by my doctor _____

_____ I was told to limit physical activity due to a heart condition or onset of chest pain during activity

_____ I have been diagnosed with any of the following: sexually transmitted disease (s) or infections

(I.e. herpes simplex, gonorrhea, HPV, etc.) Vaginitis, pelvic inflammatory disease.

_____ I have general (e.g., fever or chills, poor general health, unexplained weight loss, face numbness, jaw pain, tingling or weakness) _____

_____ I have had a recent illness not mentioned above: _____

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

PAST MEDICAL HISTORY: (*Please mark the appropriate lines with an **X**, and provide details*)

____ I have had serious infections (e.g., tuberculosis, pneumonia)_____

____ I have had the following general surgeries(e.g., appendectomy, gastrointestinal surgery, tumor removal, heart, kidney, and or lung transplant, CABG, pacemaker/pump or any other type of implant, carotid endarterectomy, laparoscopy, mastectomy, breast augmentation/reduction, cosmetic surgery, tubal ligation, ovarian cystectomy, hysterectomy, hernia repair, TURP) _____

_____

____ I have had the following orthopedic surgeries (e.g., arthroscopy, repair, reconstruction, replacement, fusion, laminectomy, discectomy, ORIF (pins, plates, screws) to any area/joint) _____

_____

____ I have had a history of falls or near falls, how many? _____ Date of the last fall _____

____ Any OTHER medical history or procedures _____

OCCUPATIONAL HISTORY: (*fill in all that apply*)

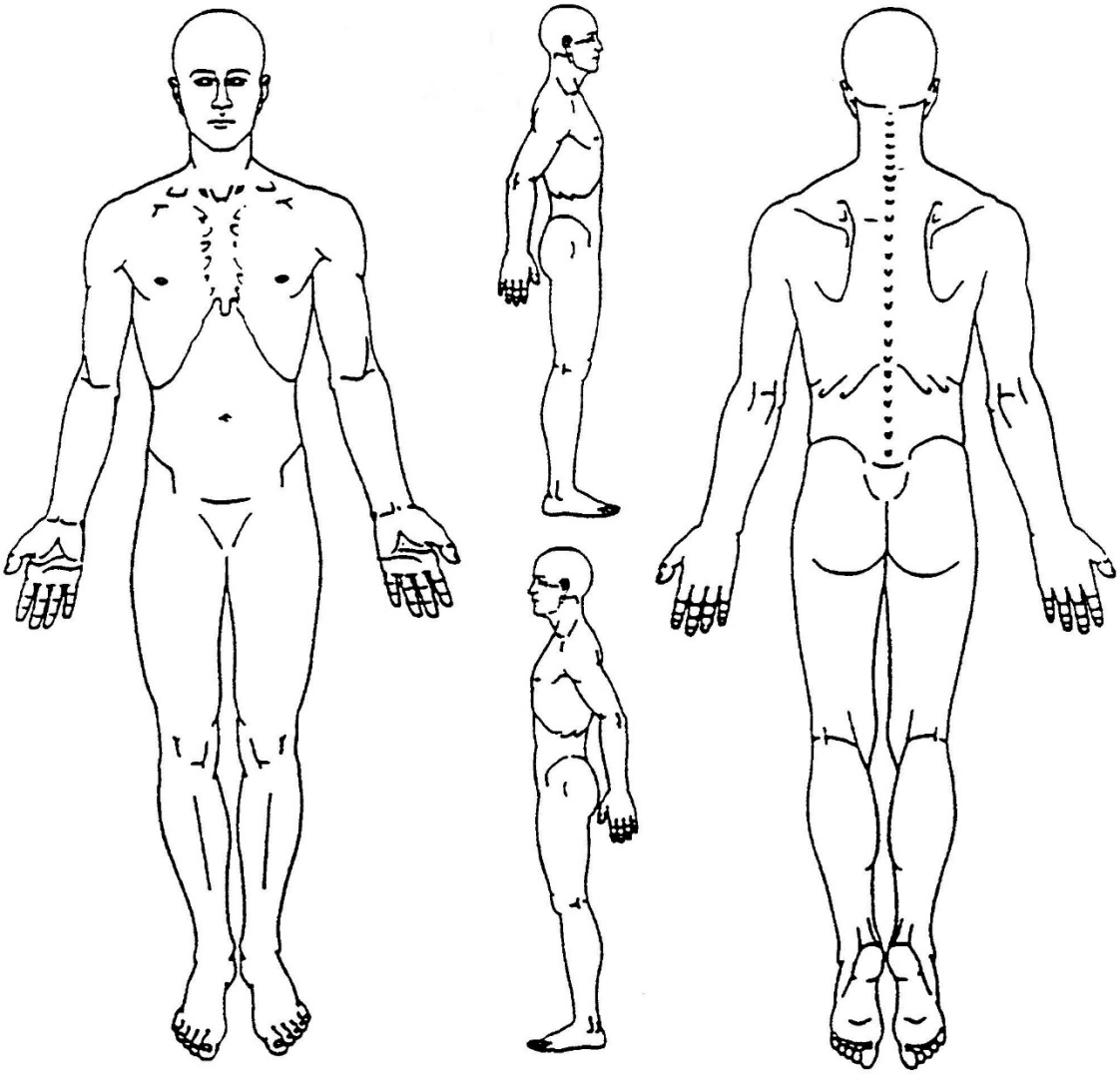
My occupation is _____

If you have work limitations/restrictions what are they? _____

My commute to work/school takes _____ minutes.

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A – ACHE B – BURNING N – NUMBNESS P – PINS & NEEDLES S – STABBING O - OTHER



PAIN SCALE Rate the severity of your pain by checking one box on the following scale.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

I verify the above information is complete and accurate, and have not omitted any medical conditions or history.

Patient or Responsible Party Name: _____ Signature _____

Date _____