Agape Physical Therapy
Serving Our Community In Love

7pPatient 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? _____

Agape Physical Therapy
Serving Our Community In Love

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, vaginitis, pelvic inflammatory disease, etc.)

_____ 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*)

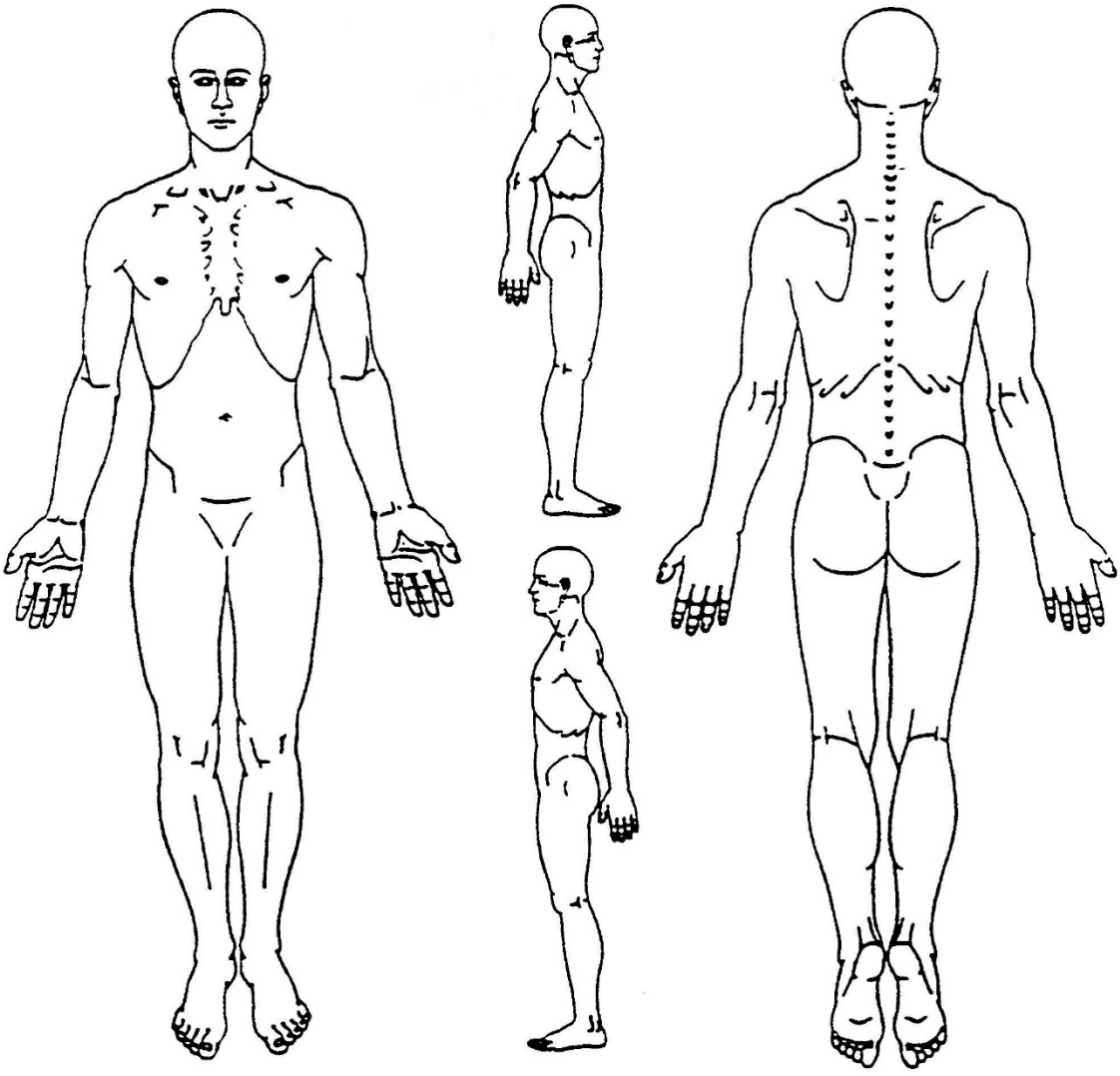
My occupation is _____

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 _____