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*)

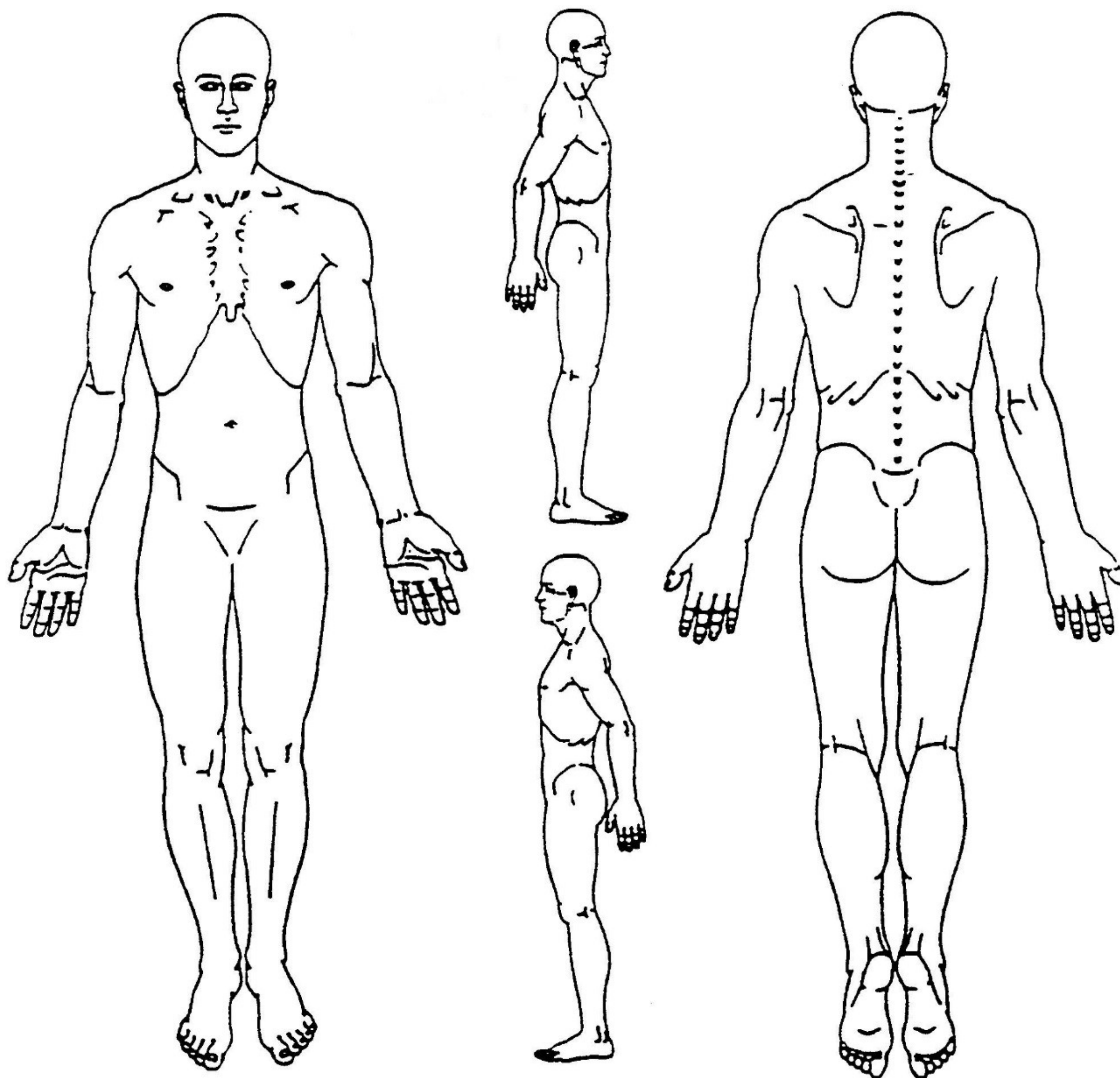
My occupation is ____

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 _________________