Patient Medical Information

Please answer the following questions:

DATE & MECHANISM OF INJURY

_____

_____

Please list medications (dosage and times taken per day) OR provide us with a list to be photocopied and placed in your chart.

_____

_____

_____

Are you currently working? What is your job title? In a few words, what activities does your job require of you?

_____

_____

_____

What are your goal(s) for physical therapy?

_____

_____

Pain Scale:
Circle the pain that you are experiencing RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain of your life

Please check any that apply to you:

_____ **Alzheimer's**
_____ **Cardiovascular Disease**
_____ **Cauda Equina Syndrome**
_____ **Cerebral Vascular Accident (stroke)**
_____ **Current Infection**
_____ **Diabetes Mellitus Type I**
_____ **Diabetes Mellitus Type II**
_____ **Fibromyalgia**
_____ **Fracture or Suspected Fracture**
_____ **Immunosuppression (HIV/AIDS, Crohn's)**
_____ **Surgical History**_____
_____ **Other** _____

_____ **History of Cancer**
_____ **Huntington's**
_____ **High Blood Pressure**
_____ **Lupus**
_____ **Muscular Dystrophy**
_____ **Osteoarthritis**
_____ **Parkinson's**
_____ **Rheumatoid Arthritis**
_____ **Traumatic Brain Injury**
_____ **Neurological Disorder**
_____ **Previous Therapy**

Patient Name (print): _____ **Date:** _____

Patient/Guardian Signature: _____