Date: ________________

What are you being seen for today? ____________________________________________________

When did this problem begin? ________________________________________________________

What makes your symptoms worse? ___________________________________________________

What makes your symptoms better? ___________________________________________________

Have you undergone any special tests for this problem (X-ray, MRI, etc)? If so, please list with results:
_________________________________________________________________________________

What would you like to achieve with therapy? ____________________________________________

Occupation: ______________________________________________________________________

Outside Interests/activities, sports, hobbies: _____________________________________________

**PAIN ASSESSMENT**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Immediate emergency, hospitalization, unable to speak, incapacitated, worst pain imaginable</td>
</tr>
<tr>
<td>8</td>
<td>Tearful, needing to lie down, needing to take extra medications, difficulty engaging in conversation</td>
</tr>
<tr>
<td>7</td>
<td>Needing to stop the activity you are currently performing, unable to maintain body position, very restricted movement</td>
</tr>
<tr>
<td>6</td>
<td>Require more breaks, slowed work rate, slowed or altered movements, lean on nearby surfaces, limp</td>
</tr>
<tr>
<td>5</td>
<td>Pain is there but is low in intensity and is manageable, no observed limitations due to pain</td>
</tr>
<tr>
<td>0</td>
<td>No pain, no limitations due to pain</td>
</tr>
</tbody>
</table>

Using the above scale, please rate your pain between 0-10:

Today:    ______

Over the past few weeks:

Best:      ______

Worst:    ______

Please circle the word(s) below that best describe your symptoms:
aching, burning, cramping, dull, heavy, numbness, pressure, radiating, sharp, tightness, tingling
other: __________________

Please mark the area of symptoms on the body diagram below:
Date: ________________

Do you have, or have you had any of the following conditions?

☐ Arthritis / Osteoporosis (Where: _________________)
☐ Kidney disease / Dialysis

☐ Blood clots
☐ Liver disease / Hepatitis

☐ Blood disease: _________________
☐ Lung disease: _________________

☐ Cancer (Type: _________________)
☐ Lymphedema (Where: _________________)

☐ Diabetes: Pills / Insulin / Diet controlled
☐ Multiple Sclerosis

☐ Drug-resistant infection / MRSA
☐ Spinal cord injury (Date: _________________)

☐ Epilepsy / Seizures
☐ Stroke / TIA (Date: _________________)

☐ Fibromyalgia
☐ Thyroid disorder: Hypo / Hyper

☐ Head injury (Date: _________________)

☐ Heart condition: _________________
☐ Hearing problem _________________

☐ Hernia
☐ Memory problem _________________

☐ High blood pressure
☐ Speech / swallowing problem

☐ Immune disorder: _________________
☐ Vision problem _________________

• Are you pregnant / nursing? (circle if yes)

• Do you smoke? YES / NO Packs/day: ____

• Do you have a history of falls? YES / NO Date of last fall: _________________
   How & where did you fall? ______________________________________________________

Please list any other medical history that we should be aware of:

___________________________________________________________________________ Date: _______ _________________ Date: _______
___________________________________________________________________________ Date: _______ _________________ Date: _______

Please list any surgeries that we should be aware of:

___________________________________________________________________________ Date: _______ _________________ Date: _______
___________________________________________________________________________ Date: _______ _________________ Date: _______

Please list current medications with dosages: ☐ No current medications

___________________________________________________________________________
___________________________________________________________________________

Please list any allergies to medications, adhesives, or latex: ☐ No known allergies

___________________________________________________________________________

Have you received any other therapy services this year? (Include nursing home, home health, etc.)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy Where: _________________