First name: Last name:

Age: Height: Weight:

Date of Birth:

Address:

Email:

Cell phone#:

Occupation:

Doctor you'd like me to contact:

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

What part of the body are you (or will you be) being treated for?

What is your major complaint?

Date of Injury?

What are your overall health goals once your complaints are resolved?

How long has it been since you really felt well?

What do you consider a realistic window of time to see changes in your health after beginning PT?

Current Pain Level:_____

0= No Pain, 2 = Mild Pain, 4= Moderate Pain, 6= Severe Pain, 8 = Very Severe Pain, 10 = Worst Possible Pain

Worst possible pain in the past week:_____

0= No Pain, 2 = Mild Pain, 4= Moderate Pain, 6= Severe Pain, 8 = Very Severe Pain, 10 = Worst Possible Pain

Least amount of pain in the last week:_____

0= No Pain, 2 = Mild Pain, 4= Moderate Pain, 6= Severe Pain, 8 = Very Severe Pain, 10 = Worst Possible Pain

LIfestyle Factors

Are you presently taking any medications, nutritional supplements or vitamins?

If YES please list Brand names and dosage per day.

How much sleep do you get per night?

Do you have any food allergies, sensitivities or restrictions?

Do you smoke, drink alcohol, or use recreational drugs? Y/N

If yes, how much and how often?

How often do you drink caffeinated beverages?

How do you deal with your stress?

How often do you exercise?

Women please answer the following questions.

a. Form of birth control _____ b. # of children _____ c. # of pregnancies _____ d. Age of first period _____ e. Date - last menstrual cycle _____ f. Length of cycle _____ days g. Interval of time between cycles_____days h. Any recent changes in normal menstrual flow 10. Nausea and/or vomiting Yes_____ No _____

Do you experience any of these symptoms during your period? Please check Yes or No. 1. Cramping in lower abdomen or pelvic area Yes_____ No _____

1. Lower abdominal pain is sharp and/or dull or intermittent Yes_____ No _____
2. Bloating and sense of abdominal fullness Yes_____ No _____
3. Diarrhea or constipation Yes_____ No _____
4. Nausea and/or vomiting Yes_____ No _____
5. Low back and/or legs ache Yes_____ No _____
6. Headaches Yes_____ No _____
7. Unusual fatigue (take naps) resulting in missed work Yes_____ No _____
8. Painful and/or swollen breasts Yes_____ No _____
9. Painful or difficult sexual intercourse Yes_____ No _____
10. Low abdominal, back and vaginal pain throughout the month Yes_____
11. Pelvic pressure or pain while sitting down or standing up, relieved by lying down Yes_____ No _____
12. Vaginal bleeding other than during your period Yes_____ No _____
13. Painful bowel movements Yes_____ No _____
14. Difficult (straining) urination Yes_____ No _____
15. Abnormal vaginal discharge Yes_____ No _____
16. Profuse or prolonged menstrual bleeding Yes_____ No _____ 12. Unable to get pregnant Yes_____ No _____

Health History

Please list any injuries you have had in the past.

1) Injury and Date of Injury:

2) Injury and Date of Injury:

3) Injury and Date of Injury:

List all surgeries starting with the most recent:

Hospitalizations:

Have you recently noted any of the following? Y/N (if yes, when?)

Weight Loss/Gain

Fever, Chills or Sweats

Dizziness/Fainting

Numbness/Tingling

Weakness/Fatigue

Nausea/Vomiting

Bowel/Bladder Problems

Problems Sleeping

Changes in Vision/Hearing

None of the above

Have you had any of the following procedures for your current complaint/injury?

X-Ray

Bone Scan

Nerve Conduction Study

Arteriogram

MRI

CT Scan

None of these

Any other procedures for this condition that are not listed?

Have you recently seen any Doctors or other Health Care practitioners for this condition?

If yes, when:

Family History

Have you or any of your family members ever been diagnosed as having any of the following conditions? Please check all that apply

Asthma

Thyroid Problems

High Blood Pressure

Depression

Tuberculosis

Kidney Problems

Epilepsy

Cancer

Emphysema/Bronchitis

Chemical Dependency (i.e. alcoholism)

Diabetes

Cardiac Problems

Hepatitis

Stroke

Anemia

Osteoporosis/Osteopenia

None of the above

If cancer was selected, what kind?

By Signing your name and today's date, you are saying that the information above is correct.

Signature: **Today's Date:**