REMEDY
PHYSICAL THERAPY

First name: Last name:

Age: Height: Weight:

Date of Birth:

Home Address:

Email:

Cell phone #:

Occupation:

Doctor you'd like me to contact:

Date of Injury?

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

What part of the body do you want to be treated for?

What can I help you with?

Why do you think this problem exists?

What are you afraid of in regards to this problem?

How long have you been dealing with this?

Is it getting better, staying the same, or getting worse?

What do you expect from PT?

What are your 3 main goals?

What activities can you currently do well?

What activities give you trouble?

Current Pain Level:_____

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? If so, list them.

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? And How often do you want to?

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 ? Please check Yes or No.

1. Leaking urine or feces Yes_____No____
2. Do you have any Prolapses? Yes_____No_____
3. Pain during urination or sex? Yes_____No_____
4. Bloating and sense of abdominal fullness Yes_____ No _____
5. Diarrhea or constipation Yes_____ No _____
6. Nausea and/or vomiting Yes_____ No _____
7. Headaches Yes_____ No _____
8. Unusual fatigue (take naps) resulting in missed work Yes_____ No _____
9. Painful and/or swollen breasts 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. Difficult (straining) toilet use Yes_____ No _____
13. 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:

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 diagnostic scans for your current complaint/injury?

If yes, what:

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 (if yes, what kind?)

Emphysema/Bronchitis

Chemical Dependency (i.e. alcoholism)

Diabetes

Cardiac Problems

Hepatitis

Stroke

Anemia

Osteoporosis/Osteopenia

None of the above

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

Signature: **Today's Date:**