123 West Broadway Street
Owatonna, MN 55060
Phone: 507-451-7888
Fax: 507-451-3322
www.intouchpt.com

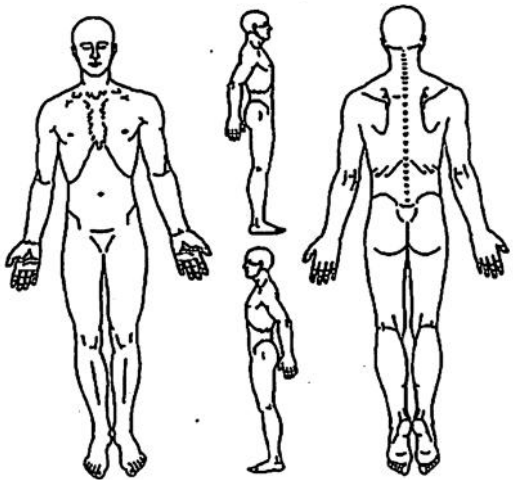
In Touch Physical Therapy

Your Pain Stops Here

Patient Name:
Date of Birth:
Date:

Current Symptoms:
What are your current symptoms and complaints?_____
_____
_____
_____
How often?_____
_____

Please indicate on the diagram below the areas of your symptoms:



Please rate your pain **today** (0=no pain, 10=worst pain)
☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Please rate your pain at **best**

☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Please rate your pain at **worst**

☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Please circle the best descriptors of your pain:

Throbbing Sharp Aching Tiring Pounding Sore
Crushing Nauseating Pulsing Burning Dull
Miserable Beating Hot Heavy

How did your injury/ symptoms occur?_____
Date of onset/ injury?_____ What makes symptoms better?_____
_____ What makes symptoms worse?_____

Please circle any limitations you have because of your condition:

Walking Reaching Lifting Sleeping Sitting Standing Stairs Bending Driving
Turning your head Breathing Coughing/sneezing Headaches; How often?_____
Other_____

For your condition, have you ever been treated by a MD(s), Physical Therapist, Dentist, Chiropractor, Injections, Acupuncture, Psychologist, Massage, Nerve ablation/rhyzototmy, Other, None (Please circle all that apply)
If so, when?_____
Do you have any other Physician appointments? If so, when?_____

Please flip over

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What is your current occupation? (Part or Full Time)_____

Do you have work restrictions?_____

What are your goals for therapy?_____

Have you had any recent surgeries?_____

Do you have a history of falls in the last year? Yes/No. If so, when & how often?_____

Apart from your daily activities, do you exercise? Yes/No. If so, how often?_____

Do you (please circle all that apply)

Live alone With family or caregivers In home/apartment/retirement complex

Have stairs or elevator Drive

Prior to your injury were you (please circle all that apply)

Independent in all activities Independent with self-care activities

Difficulty performing self-care activities Need assistance with self-care activities

Difficulty with household chores Limitations in recreation or leisure

For your condition, have you had any of the following? CT scan, MRI, X-Ray, EMG, None (Please circle all that apply)

If so, when?_____

For your condition, have you ever been treated by a MD(s), Physical Therapist, Dentist, Chiropractor, Injections, Acupuncture, Psychologist, Massage, Nerve ablation/rhyzototmy, Other, None (Please circle all that apply)

If so, when?_____

Do you have any other Physician appointments? If so, when?_____

How were you referred to In Touch Physical Therapy? (please circle all that apply)

Doctor Friend/ Family Newspaper Phone book

FOR OFFICE USE ONLY

HR_____ BP_____

Height_____

Weight_____ BMI_____