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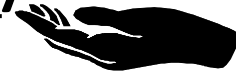
In Touch Physical Therapy

Your Pain Stops Here



Patient's Name: ______________________________

Today's Date: ________________________________

Email Address: _______________________________

Send me Monthly Email Newsletters Yes No

Emergency Contact Name: _____________________

Relationship: _________________________________

Phone Number: ______________________________

How did you learn of our service?

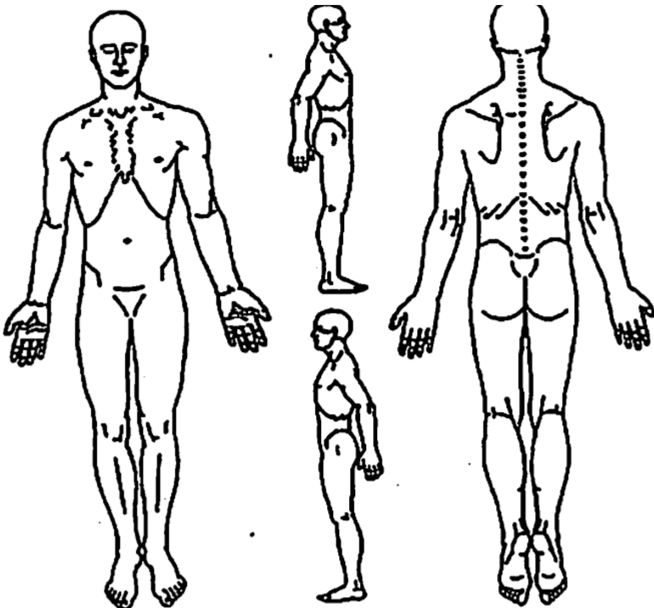
(Please circle all that apply)

Former Patient Doctor Friend / Family
Internet Newspaper / Phone book

Who can we thank for this referral?

____

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



What are your **goals for therapy**?

____

____

Current Symptoms:
What are your current symptoms and complaints?

____

____

____

How often?____

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____

Please rate your pain at **WORST** (0=no pain, 10=worst pain)

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

Please rate your pain **TODAY:**

☺ 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 circle the best descriptors of your pain:

Throbbing Sharp Dull/Aching Tiring Pounding Sore
Crushing Nauseating Pulsing Burning Dull
Miserable Beating Hot Heavy Numbness/Tingling
Other: ____

Please flip over

How did your injury/ symptoms occur?____

Date of onset/ injury? ____________What makes symptoms better?________________

What makes symptoms worse?____

For your present condition, have you ever been treated by any of the following:
(Please *circle* all that apply)

MD(s) Physical Therapist Dentist Chiropractor Injections Acupuncture

Psychologist Massage Nerve ablation/rhyzototmy Other None

If so, when?____

For your condition, have you had any of the following? (Please *circle* all that apply)

CT scan MRI X-Ray EMG None

If so, when?____

Do you… (please circle all that apply)

Live alone With family With Caregivers

House Apartment Retirement complex

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

Have you had any **recent surgeries** If so what type(s)?____

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?______________________

Is this visit due to a job-related injury or auto accident? Yes / No

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

Employer's Name:____

Do you have work restrictions?____