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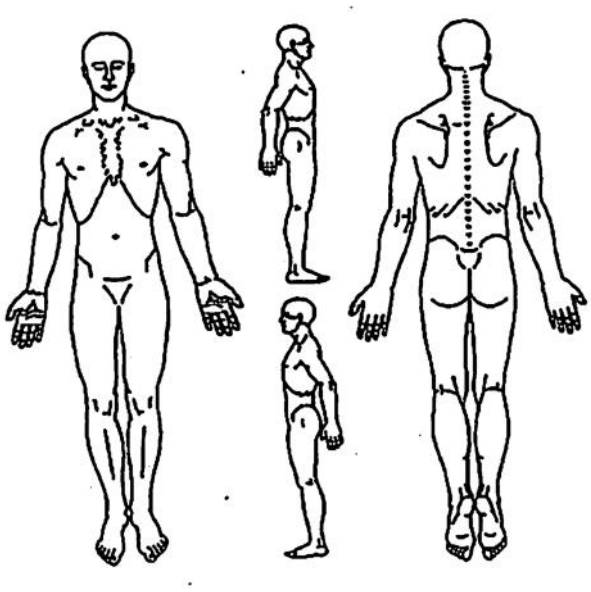
In Touch Physical Therapy

Your Pain Stops Here

Patient's Name:
Email:
Address:
Today's Date:

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 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 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_____

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

Please flip over

Office Use Only:
Patient's Name:_____
DOB:_____

For your <u>present</u> condition, have you ever been treated by… a MD(s), Physical Therapist, Dentist, Chiropractor, Injections, Acupuncture, Psychologist, Massage, Nerve ablation/rhyzotomy, Other, None (Please *circle* all that apply)
If so, when?_____

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

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?_____

Work/Employment:

Employer's Name?_____

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

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

Do you have work restrictions?_____

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?_____

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

How did you learn of our service or whom can we thank? (please circle all that apply)

I was a Former Patient Doctor Friend/ Family Newspaper Phone book

Other:_____

Would you like to sign up to our Monthly Email Newsletter? Yes or No