Patient Information Sheet

Name: _____ DOB: _____ Date: _____

To help us access the circumstances surrounding your injury, we ask you to complete this form before being seen by the physical therapist. Please answer as completely as you can.

Personal

1. Are you working? **YES NO**
2. If yes, what is your occupation and what are the physical demands?

   _____
3. If no, when was the last time that you worked and what were the physical demands?

   _____

   _____
4. What significant past medical history should we be aware of?

   _____
5. Height_____ Weight_____
6. Please Attach Current medication list with Name of Medication Dosage and how often it is taken.

Reasons for Your Appointment

1. What is your main complaint/problem?

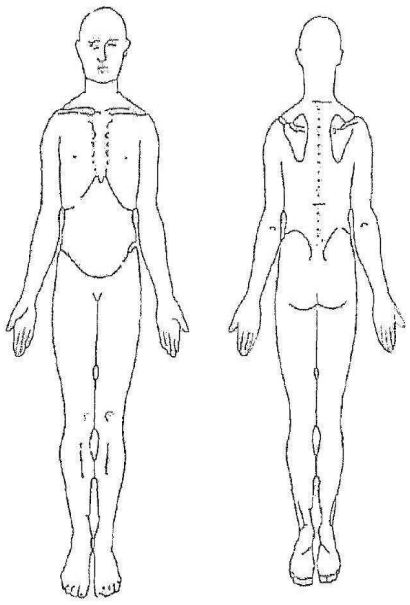
   _____
2. **Are your injuries due to a motor vehicle or other type of accident? Yes ____ No ____**
3. Please note your pain on the following scale: (On a scale of 1-10 with 10 being worse)

   1 2 3 4 5 6 7 8 9 10

   Mild Moderate Extreme
4. Please use the body diagrams to show your areas of discomfort using the following symbols:

   III Shooting pain **....** Ache /// Pain

   xxx Numbness~~~ Constant ache



5. What positions/activities *increase* your pain?

   _____

   _____
6. What positions/activities *decrease* your pain?

   _____

   _____
7. What functional skills are you unable to do now?

How long can you sit w/o pain?	How long can you stand w/o pain?
How well do you sleep?	How far can walk w/o pain?
Dressing?	Bathing?
Use stairs?	Squatting/stooping/lifting?
Reach overhead?	Other?

8. What specific job activities do you have difficulty performing?

   _____
9. What recreational activities do you have difficulty performing?

   _____

Previous Treatment

1. What tests/treatments have you had for this problem?

   _____
2. What other health care providers have you seen? (Ex. orthopedic, dentist, chiropractor)

   _____
3. Are you or could you possibly be pregnant? Have you been recently?

   _____