Patient's Name: _____ ***Today's Date*:**_____

Injury Information

Where is your pain located? _____How long have you had these symptoms?_____

Cause of Injury - Check all that apply

____Chronic symptoms ____Motor vehicle accident ____Sports/recreational ____Work related ____Overuse ____Trauma
____Unknown ____Other _____

Diagnostic Testing

____NCV/EMG ____Bone scan ____Cardiac stress test ____Doppler ____Urinalysis ____CT Scan ____Blood test
____MRI ____Ultrasound ____X-ray Results _____

Prior Treatment – Check ALL that apply

____Acupuncture ____Chiropractic ____Massage ____Rest ____Physical Therapy ____Injection
____Medication ____Other _____
____Surgery Date of surgery_____

My symptoms are RELIEVED by - Check ALL that apply

____Modifying activity ____Stopping activity ____Lying down ____Medication ____Heat ____Standing ____Ice
____Rest ____Sitting ____Walking

My symptoms are AGGRAVATED by – Check ALL that apply

____Modifying activity ____Stopping activity ____Lying down ____Medication ____Standing ____Heat ____Ice
____Rest ____Sitting ____Walking

Medical History ***List of Medical Conditions and Diseases – Check ALL that apply***

____Allergies ____Asthma ____Arthritis ____Cancer ____Cardiac conditions ____ Pacemaker
____ Pregnant ____Anxiety ____Depression ____Diabetes ____Dizzy spells ____Lung problems
____Fractures ____Kidney ____Metal implants ____Seizures ____Parkinson's ____Osteoporosis
____Strokes ____Vision ____Thyroid ____ Ulcers ____Weight loss ____Tuberculosis
____Incontinence ____Multiple sclerosis ____Circulation problems ____Gallbladder problems
____High blood pressure ____Rheumatoid arthritis

Describe any other conditions or precautions

Surgical history: Surgery type _____Date of surgery_____

Current medication(s) (use another page if needed)

Name	Dosage	Frequency/route of administration

Physical Therapist Signature _____ **Date** _____