MEDICAL INFORMATION

Name: ___________________________________ Date:______________________________

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. What brings you to therapy?____

2. Are you currently engaging in any form of exercise? YES NO If yes, list activity, frequency and intensity: ____

3. How active is your lifestyle? _____ Sedentary____ Moderate_______ Heavy________

4. What is your job title if you are currently working? ____ Describe the types of activities you do for your job? (Heavy lifting, stair climbing, walking, sitting at a desk, ETC):

5. Please indicate your goals and expectations for your treatment:

____

B1. PLEASE DISCRIBE WHERE YOU ARE FEELING THE PAIN .

B2. PLEASE SELECT THE PAIN YOU ARE FEELING .

Stabbing Pin & Needles

Burning Numbness

C. PLEASE RATE YOUR PAIN LEVELS

:

PAIN SCALE (please fill out below): 0 = no pain 10 = been to the ER for the same

PAIN AT WORST **CURRENT** **AT BEST**

PATIENT SIGNATURE: ____

DATE: ____

MEDICAL INFORMATION

NAME: ________________________________ DATE: ___________________

MEDICAL HISTORY: CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ Alzheimer's _____ High blood pressure _____ Osteoarthritis
_____ Cardiovascular Disease _____ History of cancer _____ Parkinson's
_____ Current infection _____ Pregnancy _____ CVA/Stroke
_____ Lupus ______ Diabetes Type1/Type2 _____ TBI
_____ Fibromyalgia ______ HIV, HEP B, HEP C ______ Implants (medical or cosmetic)
_____Rheumatoid Arthritis ______ Previous fractured bones and/or previous surgery (if so, please note):

PLEASE LIST BELOW *(or provide a copy of)* YOUR CURRENT PRESCRIPTION/VITAMINS/SUPPLEMENTS:

Medication/Vit/Supplement	Dosage	Frequency	Route (ex: Orally)

Any falls in the last 12 months? YES NO If yes, how many? ______________________________

Did any fall result in an injury? YES NO If yes, what injury? _____________________________

Any recent hospitalizations? YES NO If yes, what for? ________________________________

Have you completed a medical physical in the last year? ____

Are you currently receiving therapy services elsewhere? ____

Are you currently receiving Home Health? ____