Name: _____ **Date of Birth:** _____

Allied Physical Therapy
your allies for life

Please answer as completely as possible.

Personal Data:

1. Are you currently working: Y / N Job title: _____
2. Describe your job requirements: _____
3. Describe your leisure activites or hobbies: _____
4. Do you have a preferred learning method?
   No preference Written Demonstration Verbal Audiovisual
5. Describe your living arrangements:

Do you live alone? Y / N Who is available for support? _____

Required to use stairs? Y / N Are there rails available? Y / N

6. Do you require an assistive device? Walker, wheel chair, cane, use of splints
7. Dominant hand Right Left

Current Complaint:

1. Where/when did your injury occur? _____
2. How did your injury occur? _____
3. What is your main complaint or problem: _____

_____

4. Use the following scale to rate your pain (0= no pain, 10= worst imaginable pain)
   Circle your pain at rest and place an X over your pain with activity
   0 1 2 3 4 5 6 7 8 9 10
5. Describe your pain in words: You may choose from below or write in your own

constant	radiating	throbbing	_____
dull	stabbing	intermittent	_____
shooting	sharp	burning	_____

6. What makes your pain better? _____ Worse? _____
7. Do you notice numbness or tingling? Y / N
   If yes, where? _____

History:

1. Do you have any known allergies?: _____
2. Please list any significant past medical history, disease, fractures, or pain

_____

3. Have you had tests for this problem? (Please indicate dates)

X-ray _____ CT scan _____ Other _____

MRI _____ EMG _____

4. How have you treated this problem in the past?

None	Exercise	Chiropractor	Massage
Surgery	Injections	Pain Dr	Heat/Ice
Therapy	Medication	Splints/Braces	Rest

5. Please list your current medications. Attach a list if needed

_____

6. What is your goal for therapy? _____
7. Have you fallen within the last year? Y / N