FIRST CHOICE PHYSICAL THERAPY, INC.

NAME: _____ DATE: _____

DESCRIBE YOUR CURRENT INJURY/ILLNESS THAT BRINGS YOU HERE TODAY:

_____

_____

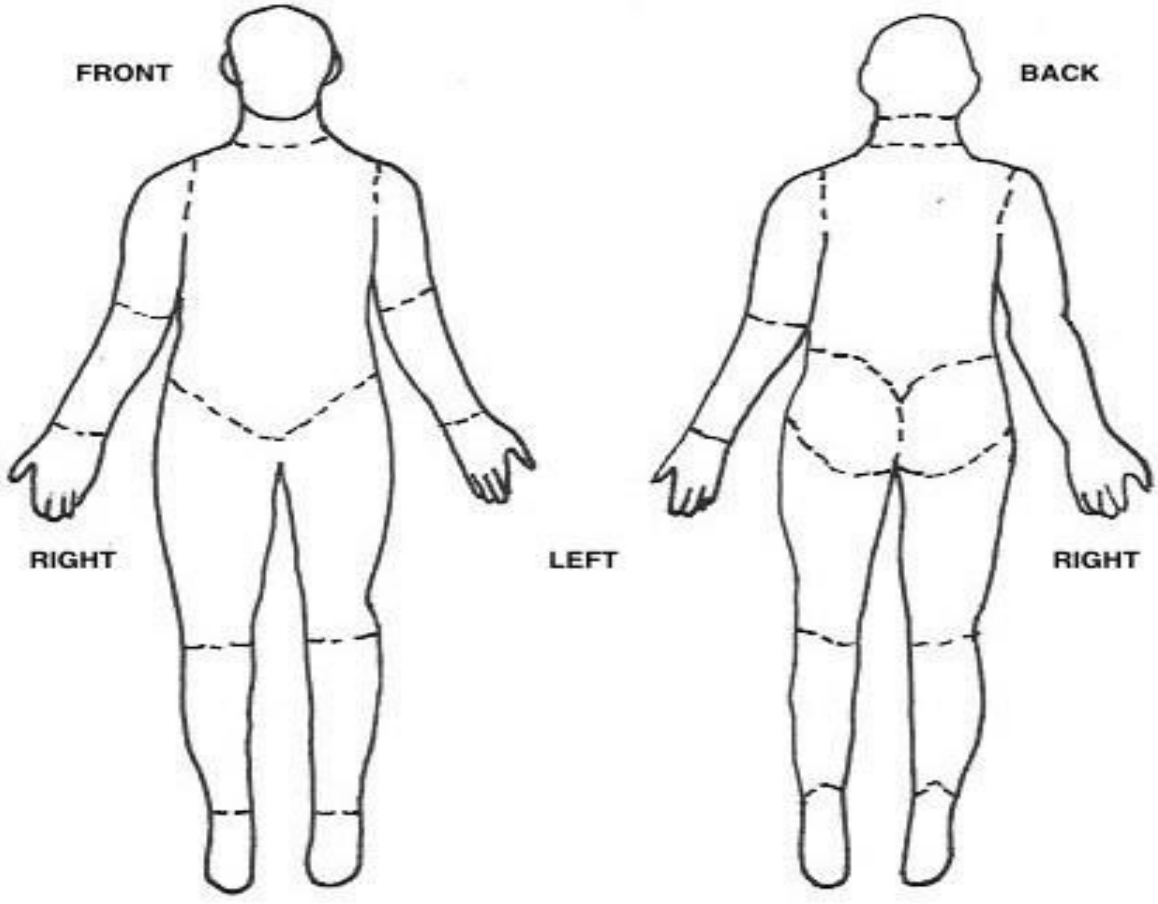
PAIN RATING: CIRCLE THE NUMBER THAT CORRESPONDS TO YOUR CURRENT PAIN

<-----0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10----->

NO PAIN

WORST PAIN IMAGINABLE

ON THE PICTURE BELOW, DIAGRAM THE LOCATION AND TYPE OF YOUR CURRENT PAIN SYMPTOMS USING THE FOLLOWING SYMBOLS:



//// SHARP/STABBING === DULL ACHE xxxx BURNING .... PINS & NEEDLES/TINGLING oooo NUMBNESS

SINCE THE PROBLEM STARTED ARE YOU? ____BETTER ____WORSE ____SAME

(PLEASE FLIP TO SIDE 2 FOR MORE ON YOUR CURRENT CONDITION & BRIEF MEDICAL HISTORY)

HAVE YOU RECEIVED ANY TREATMENT FOR YOUR CURRENT PROBLEM? __YES __NO
IF YES, DESCRIBE TREATMENT RECEIVED: _____

_____

WHAT ACTIVITIES DOES YOUR PROBLEM PREVENT YOU FROM DOING?

_____

WHAT ACTIVITIES OR POSITIONS MAKE YOU FEEL BETTER?

_____

IN THE PAST 12 MONTHS, HAVE YOU FALLEN? __NO __YES, HOW MANY TIMES?_____

WHAT IS YOUR GOAL FROM THERAPY? _____

_____

_____

MEDICAL HISTORY

LIST ANY MEDICAL CONDITIONS: _____

_____

LIST ALL PREVIOUS MAJOR SURGERIES: _____

_____

_____

ALLERGIC TO LATEX? ___YES __NO ALLERGIC TO ANY METALS? ___YES __NO

ANY MEDICATION ALLERGIES? _____

ANY OTHER ALLERGIES NOT LISTED? _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (IF NOT SURE OF NAME, LIST WHAT YOU ARE TAKING THEM FOR): _____

_____

_____

_____

CURRENT HEIGHT? _____ CURRENT WEIGHT?_____