

SUMMARY LIST

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you.

NAME: _____ PHYSICIAN: _____
OCCUPATION: _____ LEISURE ACTIVITIES: _____
PHONE # (work/day time): _____ DATE OF BIRTH: _____
DIAGNOSIS _____

Are you currently seeing any of the following?:

YES	NO	Medical Doctor (MD)	YES	NO	Psychiatrist/Psychologist
YES	NO	Osteopath	YES	NO	Physical Therapist
YES	NO	Dentist	YES	NO	Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

Have you EVER been diagnosed as having any of the following conditions?

YES	NO	Cancer. If YES, describe what kind: _____
		Are you currently being treated? YES NO In what year? _____
YES	NO	Heart problems If YES, Do you take/carry nitroglycerine? YES NO
YES	NO	Circulation problems
YES	NO	High blood pressure
YES	NO	Asthma
YES	NO	Emphysema/Bronchitis
YES	NO	Chemical dependency (i.e., alcoholism)
YES	NO	Smoke
YES	NO	Diabetes
YES	NO	Multiple sclerosis
YES	NO	Rheumatoid arthritis
YES	NO	Other arthritic conditions (osteoporosis, osteoarthritis)
YES	NO	Depression
YES	NO	Hepatitis
YES	NO	Tuberculosis
YES	NO	Stroke
YES	NO	Kidney disease
YES	NO	Anemia
YES	NO	Epilepsy
YES	NO	Other: _____

Please list any surgeries or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization:

<u>DATE</u>	<u>SURGERY/HOSPITALIZATION</u>	<u>REASON</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any injuries for which you have been treated (including fracture, dislocations, and sprains) and the approximate date of injury:

<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES	NO	Aspirin	YES	NO	Tylenol
YES	NO	Advil/Motrin/Ibuprofen/Aleve	YES	NO	Laxatives
YES	NO	Decongestants	YES	NO	Antihistamines
YES	NO	Antacid	YES	NO	Vitamins/mineral supplements
YES	NO	Other _____			

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injections and/or skin patches): _____

YES	NO	Ladies: is there any possibility that you may be pregnant?
YES	NO	Do you have any known allergies? _____
YES	NO	Do you have any known skin sensitivities (e.g., latex, lotions, etc.) or skin disorders? _____
YES	NO	Have you had 2 or more falls in the past year or any fall with injury in the past year?
YES	NO	Are you interested in a consultation/referral to a dietician for a nutritional assessment?
YES	NO	Do you have any barriers that will impact your ability to understand the information provided by your therapist (ie. Vision, Hearing, Learning, Language)

Please use the space provided to list any other conditions of which we should be aware:

Have you recently noted:

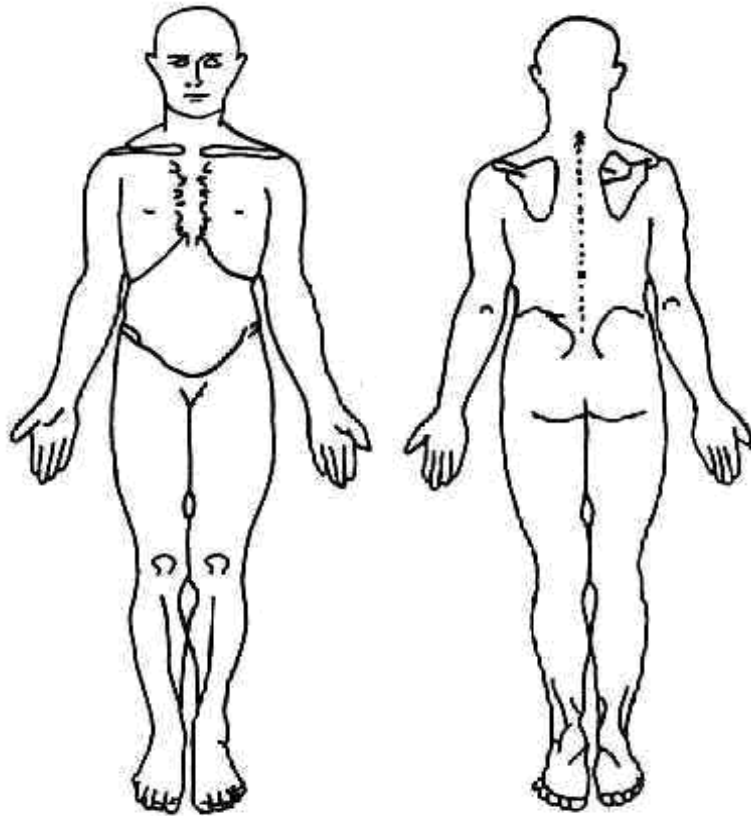
YES	NO	Weight loss/gain (unexplained)
YES	NO	Nausea/vomiting
YES	NO	Fatigue
YES	NO	Weakness
YES	NO	Fever/chills/sweats
YES	NO	Numbness or tingling?

Form reviewed with patient? YES _____ NO _____

Therapist signature

Date

On the drawings below, indicate pain location by shading in the area or areas involved. Refer to the key and place numbers that correspond to the pain's characteristic over the appropriate shaded area. Also indicate areas of numbness. Please indicate areas of pain or numbness relating to the present injury or condition.



KEY:

1. Dull ache
2. Stabbing
3. Pins and Needles
4. Burning
5. Numbness

Please rate your pain on a scale of 0-10 with 0= no pain and 10= worst pain possible.

Best _____

Worst _____

Now _____

