What problem brought you to therapy? ____________________________________________

____________________________________________

Was this an accident? (Circle One) YES NO If Yes, date of injury: ______________

Location of injury/accident (street or business name) ______________________

Have you had this problem before? (Circle One) YES NO When? ______________________

Since the onset, do you feel better or worse? ______________________________

What causes your symptoms to increase? ______________________________

What causes your symptoms to decrease? ______________________________

Have you been , or are you being treated for other medical problems? (Circle One) YES NO
If yes, what are they: ______________________________

Have you had any recent or past procedures or surgeries? (Circle One) YES NO

Please list procedures/surgeries (include dates if known): ______________________

____________________________________________

____________________________________________

Do you have any known allergies? (Circle One) YES NO

If YES, what are you allergic to: ______________________________

Are you latex sensitive? (Circle One) YES NO

Are you currently receiving services from a home care agency? (Circle One) YES NO

If YES, which Agency ______________________________

When is your next doctor's appointment? ______________________________

Please rate your pain below ( 0 = No Pain, 10 = Most Severe Pain)

| At Rest | With Activity | Pain Goal w/activity to maintain function |
| --- | --- | --- |
| **0 1 2 3 4 5 6 7 8 9 10** | **0 1 2 3 4 5 6 7 8 9 10** | **0 1 2 3 4 5 6 7 8 9 10** |

***I give my consent to treatment for this condition.***

Print Patients Name: ______________________________

Patient Signature: ______________________ Date: ______________