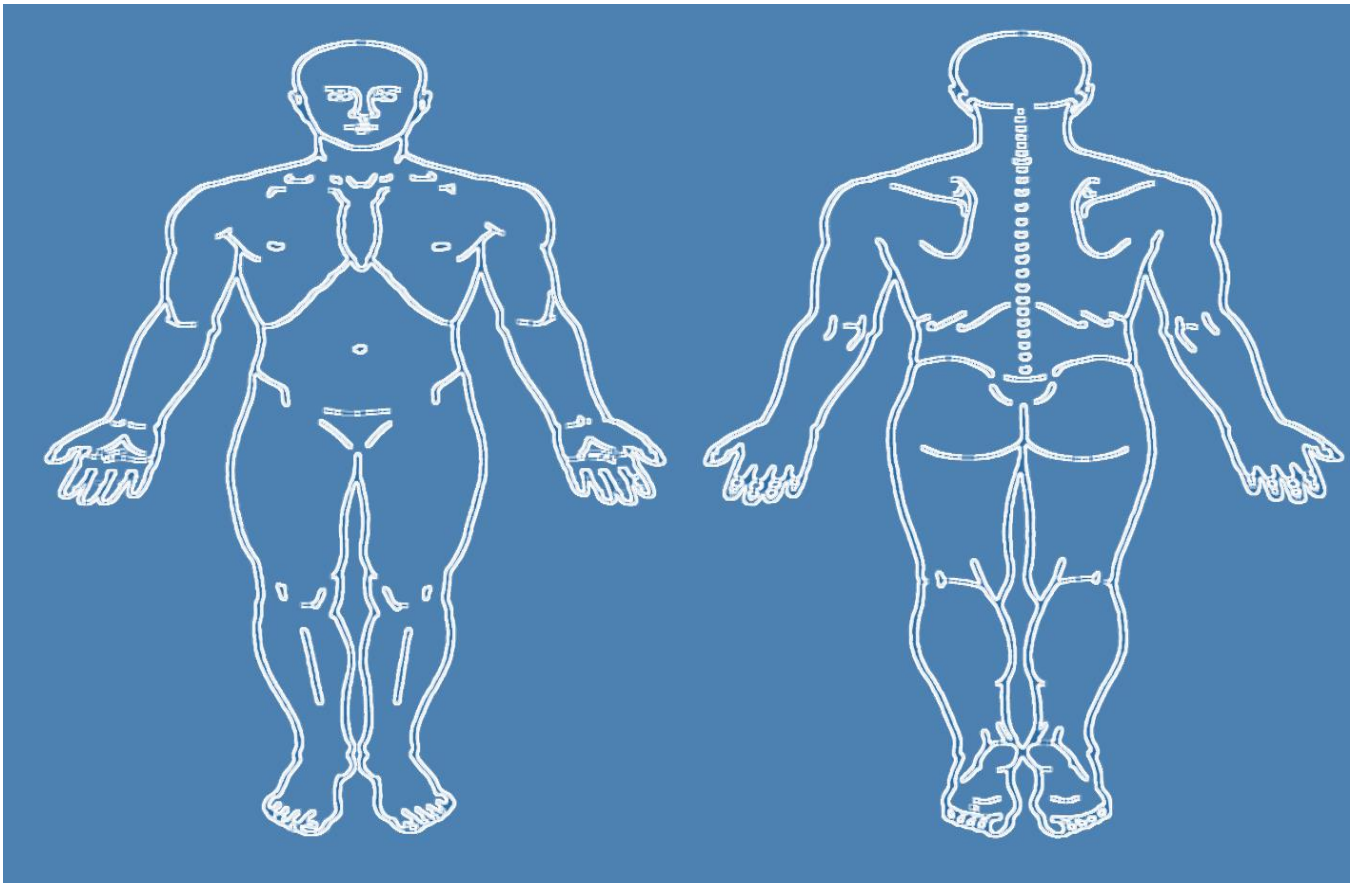
ABSOLUTE MOTION

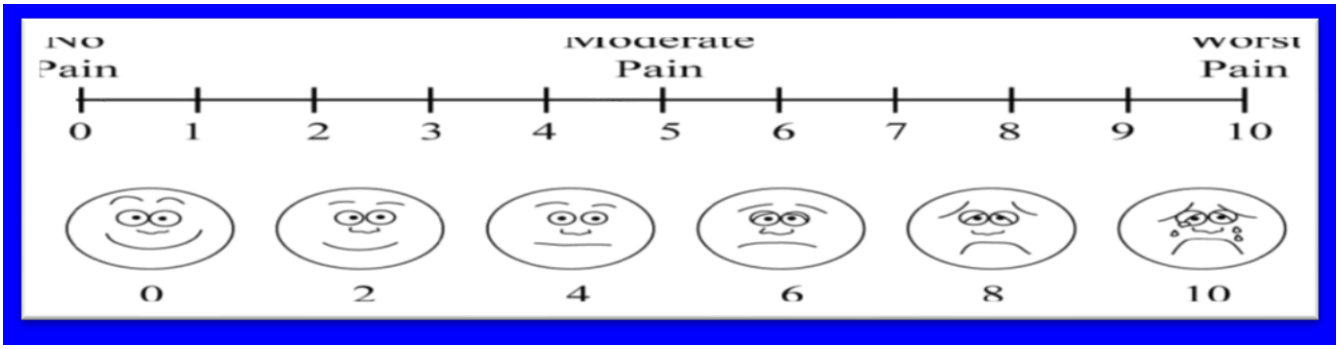
PLAN OF CARE		
FIRST NAME:	MIDDLE NAME:	LAST NAME:
SOC DATE:	ONSET DATE:	DIAGNOSTICS (X-RAY, CT, MRI):
PRIMARY DIAGNOSIS:	COMPLAINT:	LEISURE/ACTIVITIES:
DATE OF BIRTH:	SEX:	TREATMENT START DATE:
TYPE OF THERAPY: ***PT/OT***	REFERRING PHYSICIAN'S FULL NAME:	
Medical Screening Questionnaire:		
What is your height and weight?		
Are you a smoker or any alcohol use?		
Any chronic progressive illness?		
Are you employed now?		
Pertinent Past Medical/Surgical History:		
Any past Therapy:		
Prescription Medication Use:		

Over-The-Counter Medication Use such as Vitamins:	
Are you taking medication for pain?	
Have you recently taken/injected with steroids medications now or in the past?	
Are you taking any blood thinner or any anticoagulant medications for any problems?	
Detailed result of any recent diagnostic testing done such as X-ray, MRI, CT scan, bone scan.	
Describe your pain or current symptoms:	
List any major Joint Replacement surgeries and Fracture surgeries (if any):	
Depression Questionnaires:	
During the past month, have you often been bother by feeling down, depressed, or hopeless?	
During the past month, have you often been bother by little interest or pleasure in doing things?	

Look at the diagram below and **Mark an (X)** on the areas with pain and discomfort. **Encircle** the areas with shooting pain, numbness, and tingling. **Put C for constant pain, I for intermittent pain, G for gradual onset of pain, S for sudden onset** of pain.



PRESENT PAIN SCORE:_____ WORST PAIN SCORE:_____ BEST PAIN SCORE:_____



Encircle the rating of your pain based on the visual analogue scale from 0 to 10, **with 0 being no pain and 10 the worst pain you could imagine.**

ACTIVITIES THAT DECREASE PAIN: _____

ACTIVITIES THAT INCREASE PAIN: _____

To better serve you, please check if you have/had any of the following:

Symptoms/General Health Questions:

- ❑ Fever and chills
- ❑ Unexplained weight loss or gain
- ❑ UE/LE fracture _____
- ❑ UE/LE joint replacement surgery,
- ❑ Radiating pains, _____
- ❑ Stabbing pains, _____
- ❑ Throbbing pain, _____
- ❑ burning pain, _____
- ❑ Dizziness and giddiness
- ❑ Chest pain at rest, when _____
- ❑ Shortness of breath, frequency _____
- ❑ Loss of consciousness or syncope, date_____
- ❑ Coughing more than 2 weeks.
- ❑ Chest pains with activities
- ❑ Easily fatigued for no reason
- ❑ Rapid heartbeat or palpitations
- ❑ High/Low blood pressure
- ❑ Pacemaker
- ❑ Any psychiatric symptoms
- ❑ Sores/Ulcers
- ❑ Allergies _____ _____
- ❑ Feeling down or hopeless
- ❑ Increased pain at night
- ❑ Difficulty or pain with urination
- ❑ Frequency/Urgency of urination
- ❑ Difficulty or pain in bowel movement
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowel color/movement
- ❑ Vaginal/Penis discharge
- ❑ Pain on intercourse
- ❑ Irregular and pain during menstruation
- ❑ Recent vision changes
- ❑ Double vision
- ❑ Ear ringing
- ❑ Memory loss
- ❑ Vertigo
- ❑ Increased confusion
- ❑ High stress level
- ❑ Increased anxiety
- ❑ Panic attacks
- ❑ Insomnia
- ❑ Severe and intractable headaches
- ❑ Any falls or balance issues
- ❑ Other _____

Conditions/ Contraindications:

- ❑ Active or history of Cancer
- ❑ Heart problems
- ❑ Lung problems
- ❑ Aneurysm
- ❑ Blood clots
- ❑ Stroke
- ❑ Anemia
- ❑ Depression
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Gastrointestinal problems
- ❑ Rheumatoid Arthritis
- ❑ Lupus
- ❑ Osteoarthritis
- ❑ Kidney problems
- ❑ Infections. _____
- ❑ STDs/HIV
- ❑ Liver problems
- ❑ Thyroid problems
- ❑ Parkinson's disease
- ❑ Multiple sclerosis
- ❑ Dementia
- ❑ Epilepsy
- ❑ Other movement disorders
- ❑ Diabetes, type _____
- ❑ Osteoporosis
- ❑ Fibromyalgia
- ❑ Circulatory disorder

THANK YOU FOR YOUR COOPERATION!