CUTTING EDGE
PHYSICAL THERAPY

To help us provide you with a complete and thorough evaluation, please provide the following information to the best of your ability. If you do not understand a questions, leave it blank and your therapist will assist you.

Name:_____ Date of Birth:_____ Today's Date:_____

What is your primary complaint? _____

What are your goals for therapy?_____

When did your condition begin? _____

Is this a workers' compensation injury? _____ Yes _____ No

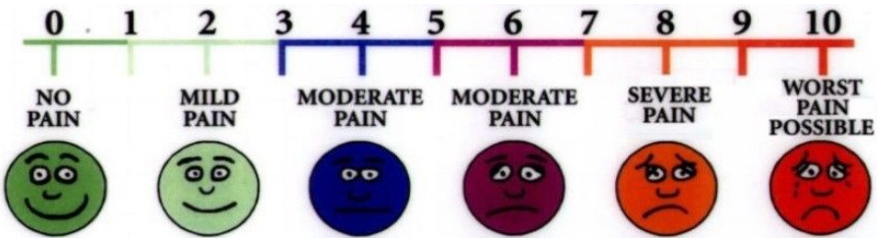
Is this resulting from a motor vehicle accident? _____ Yes _____ No

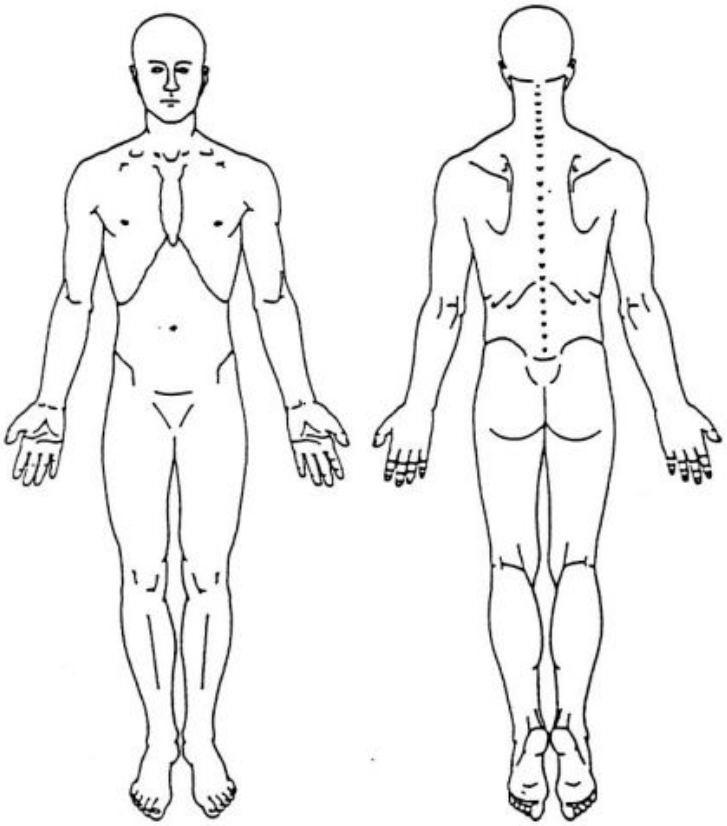
Are you currently pregnant? _____ Yes _____ No If so, how many weeks? _____

Have you had any imaging done regarding this condition?
_____X-ray _____MRI _____CT Scan _____Other: _____

Have you had surgery for this condition? ____ Yes ____ No Date:_____

Please indicate the severity of your symptoms





Please mark your area of pain on the drawings to the right.

Please describe your symptoms (check all that apply):

____ Aching ____ Burning
____ Stabbing ____ Numbness
____ Tingling ____ Throbbing
____ Other: _____

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Are you currently: (check one)

_____ Working at your usual job without restrictions
_____ Working at your usual job with restrictions
_____ Unable to work because of this injury/condition
_____ Unable to work because of another medical condition
_____ Retired

Have you recently noticed any of the following:

Weight Gain/Loss	____ Yes	____ No
Fatigue	____ Yes	____ No
Fever/Chills/Sweats	____ Yes	____ No
Nausea/Vomiting	____ Yes	____ No
Weakness	____ Yes	____ No
Numbness/Tingling	____ Yes	____ No

Please list any medications/supplements you are currently taking, including prescriptions, over-the-counter medications, injections, or skin patches (if you would like us to photocopy a pre-written list, please let us know):

_____
_____
_____

If you have had any changes in your surgical or medical history since you last saw us, please indicate those changes:

_____
_____
_____
_____
_____

Signature of patient or legal guardian:_____ Date:_____