Patient Medical Information

Please answer the following questions:



DATE & MECHANISM OF INJURY Please list medications (dosage and times taken per day) OR provide us with a list to be photocopied and placed in your chart. Are you currently working? What is your job title? In a few words, what activities does your job require of you? What are your goal(s) for physical therapy? Pain Scale: Circle the pain that you are experiencing RIGHT NOW. 4 2 3 5 8 9 10 No pain Worst pain of your life Please check any that apply to you: ____ Alzheimer's ____ History of Cancer ____ Huntington's Cardiovascular Disease ____ High Blood Pressure ____ Cauda Equina Syndrome _____ Cerebral Vascular Accident (stroke) ____ Lupus ____ Current Infection ____ Muscular Dystrophy ____ Osteoarthritis Diabetes Mellitus Type I ____ Parkinson's _____ Diabetes Mellitus Type II ____ Rheumatoid Arthritis Fibromyalgia ____ Traumatic Brain Injury Fracture or Suspected Fracture _____ Immunosuppression (HIV/AIDS, Crohn's) _____ Neurological Disorder **Previous Therapy** Surgical History ____ Other ____ Patient Name (print): _______Date: _____ Patient/Guardian Signature: