Name:

CONNECT MOVEMENT CENTER
MOVEMENT AND COMPASSION FOR ALL

Medical History Please circle or mark ALL topics/diagnoses related to you:

Allergies (please specify):	Exercise (times/week):	Parkinson's Disease
		Pelvic pain
	Gout	Pneumonia
Anemia	Head trauma	Rheumatoid arthritis
Angina	Hearing difficulties	Severe/frequent headache
Asthma	Heart arrhythmia	Sleeping problems
Back Pain	Heart attack	Smoke (please specify substance and frequency):
Balance Problems	Hernia	Speech difficulties/problems
Blood clot/emboli	High blood pressure	Stroke
Bowel/bladder problems	Kidney Disease	Thyroid problem
Cancer (specify type):	Long term steroid use	Tumors, lumps, or bumps
	Low Blood Sugar	Ulcers
Coronary Artery Disease	Lung Problems	Varicose veins
Currently pregnant	Neck/cervical trauma	Vertigo
Currently nursing	Multiple Sclerosis	Vision difficulties
Diabetes (specify type):	Osteoarthritis (specify joints):	Weakness
Dizziness or faintness		Weight loss/energy loss
Drink Alcohol (specify times/week)	Osteoporosis	Women's health issues
Epilepsy/Seizures	Pacemaker	Men's health issues
Other diagnoses or anything else we should know about you (please specify):		
Please list past surgeries/medical procedures with approximate dates:		
Please list ALL medications you are currently taking with their dosages (or provide a separate list with this information):		

Yes	No	In the past 3 months, have you had or do you experience:
		A change in your health?
		Nausea/vomiting?
		Fever/chills/sweats?
		Unexplained weight change?
		Numbness/tingling?
		Changes in appetite?
		Difficulty swallowing?
		Changes in bowel/bladder function?
		Shortness of breath?
		Dizziness?
		Upper respiratory infection?
		Urinary tract infection?

PHQ-4		Over the last 2 weeks, have you been bothered by any of the following problems?
Yes	No	
		1) Feeling nervous, anxious, or on edge
		2) Not being able to stop worrying
		3) Little interest or pleasure in doing things
		4) Feeling down, depressed, or hopeless
		If you answered "Yes" to any of the 4 questions, are you receiving treatment for this?
		If you answered "Yes" to any of the 4 questions, and are not receiving treatment, is this something you would like help with?

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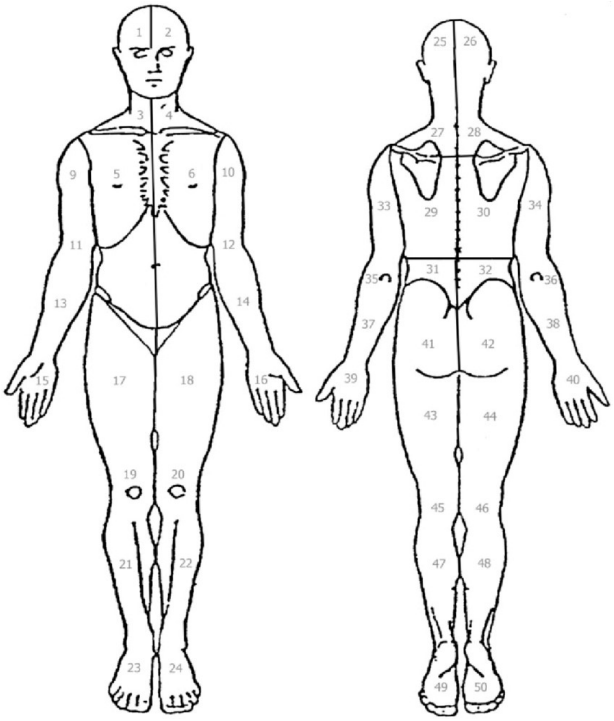
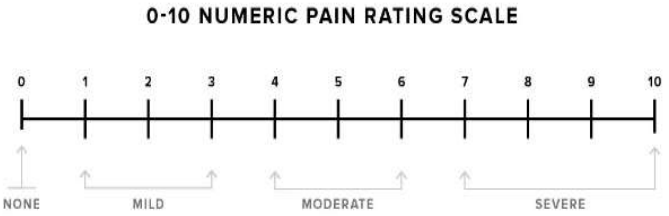
1.	Please specify the date you last saw your physician:
2.	In the past year, how many times have you fallen?
3.	If applicable, have you suffered an injury as a result of a fall?
4.	What is the main reason you are seeking physical therapy?
5.	What was the original date of injury or start of your symptoms?
6.	Have you had any imaging (such as x-ray, MRI, etc.)? If so, please specify with date(s).
7.	If applicable, does your current injury/diagnosis impact your ability to work? Please explain.
8.	Does your daily routine, or work, aggravate your injury? Please explain.
9.	What are your goals for physical therapy?

Using the diagram below, please mark the areas you have experienced pain in the last 72 hours





Main area of concern: _____

Using the pain scale above, for your *main area of concern,* please indicate a number corresponding to your:

Current pain level _____

Worst pain level in the last 72 hours _____

Best pain level in the last 72 hours _____

I certify that information provided by me in this packet is true and correct to the best of my knowledge.

Signature: _____ Date: _____