redbird physio

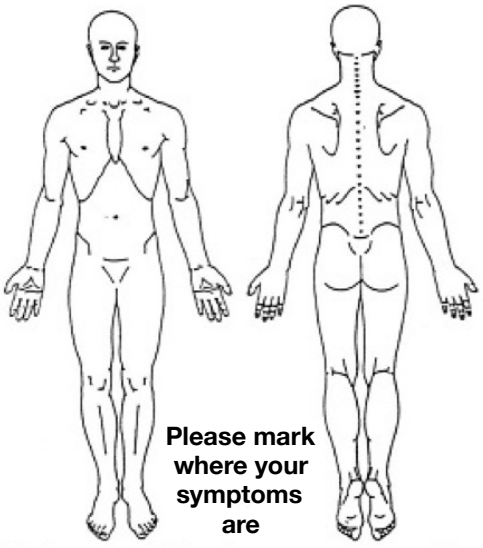
Name: _____ Height: _____

Date: _____ Weight: _____

In order to allow the therapist to have a better understanding of the nature of your injury & evaluate your condition fully, please complete the following questions as accurately as possible. Thank you!

1. When did your symptoms first start (date)? _____
2. Briefly describe how your symptoms began or how your injury occurred: _____
3. The onset of my symptoms was: ☐ Gradual ☐ Sudden
4. What are your symptoms (i.e. pain, numbness, tingling, etc)?

   _____
5. What is your worst pain (0 = none; 10 = worst)? _____
6. What is your current pain (0-10)? _____
7. What is your best pain (0-10)? _____
8. Type of pain? ☐ Sharp ☐ Dull ☐ Throb ☐ Ache ☐ Pressure ☐ Burning
   ☐ Cramping ☐ Tingling ☐ Numbness ☐ Discomfort ☐ Stabbing
9. My symptoms have: ☐ Worsened ☐ Remained the same ☐ Improved
10. My symptoms bother me: ☐ Constantly ☐ Most of the time ☐ Occasionally



Please mark where your symptoms are

11. What makes your symptoms worse? _____
12. What makes your symptoms better? _____
13. Since the onset of these symptoms, have you noticed any of the following:
    A. Regular numbness or tingling? ☐ Yes ☐ No If yes, where? _____
    B. Bowel/Bladder control difficulties? ☐ Yes ☐ No
14. Have you had a doctor's appointment for these symptoms? ☐ Yes ☐ No If yes, when? _____
15. Have you had surgery for these symptoms? ☐ Yes ☐ No If yes, when? _____
16. Have you had any imaging for you symptoms? ☐ Yes ☐ No If yes, when? _____
    ☐ X-ray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Ultrasound

    What were the findings? _____
17. Have you had these symptoms before? ☐ Yes ☐ No
    If yes, did you receive treatment? ☐ Yes ☐ No If yes, did the treatment help? ☐ Yes ☐ No

    What did the treatment consist of? _____
18. List 3 activities you are having difficulty doing as a result of your symptoms and rate on a scale of 0-10
    (0 = unable to perform, 10 = no difficulty):

    _____

    _____

    _____

19. What are your goals for physical therapy? _____

_____

20. Please rate your overall health on a scale of 1-10 (1 = poor, 10 = excellent): _____

21. Do you exercise? ☐ Yes ☐ No How many times a week do you exercise? _____

What do you do for exercise/recreation? _____

22. Is there anything else about you or your symptoms that you would like us to know? _____

_____

Medical History

☐ Allergies	☐ Dizzy Spells	☐ MRSA
☐ Anemia	☐ Emphysema/Bronchitis	☐ Multiple Sclerosis
☐ Anxiety	☐ Fibromyalgia	☐ Muscular Disease
☐ Arthritis	☐ Fractures	☐ Osteoporosis
☐ Asthma	☐ Gallbladder Problems	☐ Parkinson's Disease
☐ Autoimmune Disorder	☐ Headaches	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hearing Impairment	☐ Seizures
☐ Cardiac Conditions	☐ Hepatitis	☐ Smoking
☐ Cardiac Pacemaker	☐ High Cholesterol	☐ Speech Problems
☐ Chemical Dependency	☐ High/Low Blood Pressure	☐ Strokes
☐ Circulation Problems	☐ HIV/AIDS	☐ Thyroid Disease
☐ Currently Pregnant	☐ Incontinence	☐ Tuberculosis
☐ Depression	☐ Kidney Problems	☐ Vision Problems
☐ Diabetes	☐ Metal Implants	☐ Other

Have you RECENTLY noticed any of the following:

☐ Weight gain/loss	☐ Night pain	☐ Dizziness
☐ Impaired bowel/bladder function	☐ Fatigue	☐ Fever/Chills/Sweats
☐ Nausea/Vomiting	☐ Weakness	

Fall History

Is this injury the result of a fall? ☐ Yes ☐ No

Have you had 2 or more falls in the past year? ☐ Yes ☐ No If yes, please explain: _____

_____

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Current Medications: Please provide a copy of your entire medication list

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____