PHYSICAL THERAPY UNLIMITED, Inc.

Patient Name _____ Primary Language _____

Describe Your Current Problem and How It Began _____

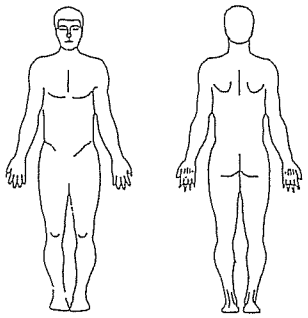
_____

What goals do you wish to achieve with therapy? _____

_____

Onset date/Surgery date _____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

☐ Allergies
☐ Arthritis/Gout
☐ Cancer
☐ Diabetes
☐ High Blood Pressure
☐ Blood Clots
☐ Fibromyalgia
☐ Myofascial pain syndrome
☐ Urinary Problems
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Surgeries _____

☐ Heart Problems
☐ Angina
☐ Shortness of breath
☐ Kidney Disease
☐ Hepatitis
☐ Gullain-Barre syndrome
☐ Thyroid problems
☐ Recent Fever
☐ Osteoporosis
☐ Other Health Problems _____

☐ Seizures
☐ Stroke
☐ Pregnancy
☐ Polio
☐ Multiple Sclerosis
☐ Shingles
☐ Dizziness/Fainting
☐ Rheumatoid Arthritis
☐ Pain at night

Who have you seen for your condition before today?

☐ No One ☐ Medical Doctor ☐ Massage Therapist ☐ Other _____
☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist

What treatment did you receive and when? _____

What is your occupation? _____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient Signature _____ Date _____