CURRENT COMPLAINTS

Patient's Name:_____ **Date of Birth**:_____

CURRENT CONDITION(S)/CHIEF COMPLAINTS

1. Who referred you to Physical Therapy?

_____

2. Please indicate the body part(s) to be treated today.

☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist/Hand
☐ Back ☐ Hip ☐ Knee ☐ Ankle/Foot
☐ Other:_____
a. ☐ Left ☐ Right

3. When did the problem begin (date of injury)?

_____

4. How did it happen?

a. Injury? ☐ Yes ☐ No ☐ Unknown
b. How did the injury occur? ☐ Accident
☐ Fall
☐ In competition
☐ Other _____
c. Where did the injury occur? ☐ Work ☐ Home
☐ Other _____
d. Surgery Performed? ☐ Yes ☐ No
Date of surgery:_____

5. Have you had this problem(s) before? ☐ Yes ☐ No

a. What did you do for the problem(s)?
☐ Physical Therapy ☐ Medication ☐ Physician
☐ Chiropractor ☐ Other _____

b. Did the problem(s) get better? ☐ Yes ☐ No
c. How long did the problem(s) last?_____

6. Have you had any of the following tests for your current problem?

☐ X-rays ☐ CT Scan ☐ MRI
☐ Bone Scan ☐ Nerve Conduction Study

7. Do you currently use any of the following?

☐ Cane ☐ Glasses ☐ Crutches
☐ Hearing Aid ☐ Walker ☐ Brace
☐ Pacemaker ☐ Manual Wheelchair
☐ Motorized Wheelchair
☐ Other:_____

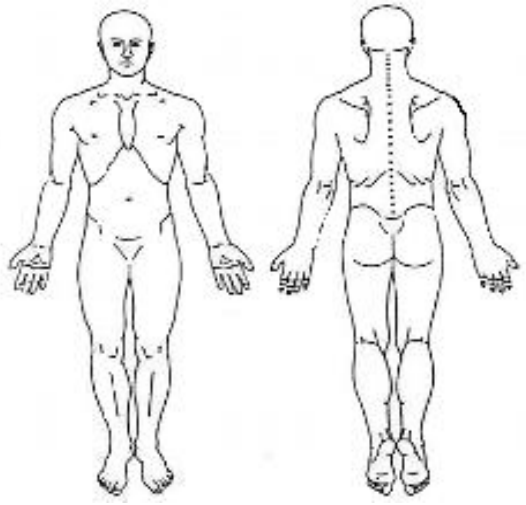
8. Are you seeing anyone else for the problem(s)?

☐ Acupuncturist ☐ Orthopedist
☐ Cardiologist ☐ Osteopath
☐ Chiropractor ☐ Podiatrist
☐ Family Practitioner ☐ Psychologist/Counselor
☐ Internist ☐ Physiatrist
☐ Massage Therapist ☐ Rheumatologist
☐ Neurologist ☐ Other _____
☐ Ob/Gyn

9. Please list the three activities that are most difficult for you because of this current injury:

1. _____
2. _____
3. _____

10. On the diagram below please indicate where you are currently having pain:



11. Using the pain scale below please chose one number that best answers the following **three questions**:

PAIN SCALE: *(Worst possible pain)*
(No pain) 0 1 2 3 4 5 6 7 8 9 10

a. What is your pain level AT ITS WORST? _____
b. What is your pain level RIGHT NOW?_____
c. What is your pain level AT ITS BEST? _____

Patient/Guardian Signature:_____ Date:_____

Reviewed by:_____ License #:_____ Date_____