Building strength and mobility

Reboot

HEALTH INFORMATION

Name: _____ **Today's Date:** _____

Age: _____ **Date of Birth:** _____ **Sex: M / F** **Marital Status: S / M / D / W**

Occupation: _____ **Are you: Right Handed / Light Handed**

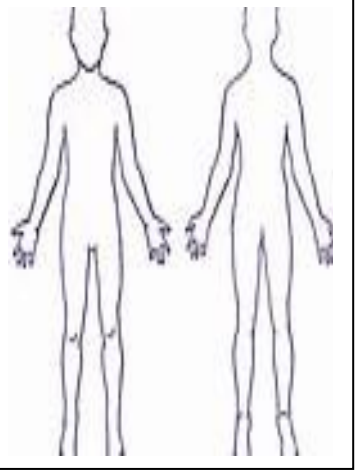
Please indicate for which body region you are seeking treatment:

__Neck __Mid Back __Low Back __Shoulder __Elbow __Hand/Wrist __Hip __Knee __ Ankle/Foot __ Other_____

When did your symptoms start? Date _____ How did it begin? Gradual / Sudden

Can you identify a cause for your symptoms? Yes / No

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN



If yes, specify: _____

Current Complaint: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How often are your symptoms present? _____

In the past week has your pain interfered with your daily activities? Chores?

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

Have you had Spinal X-Rays, MRI, CT SCAN for your areas of complaint? Yes / No

Date Taken: _____ What areas were taken: _____

Please circle all of the following that apply to you:

Recent Fever High Blood Pressure Stroke Marked Morning Pain Asthma Cancer

Autoimmune Disorder Cardiac Conditions Cardiac Pacemaker Chemical Dependency Depression

Circulation Problems Currently Pregnant Diabetes Dizzy Spells Emphysema/Bronchitis

Fibromyalgia Fractures Gallbladder Problems Headaches Hearing Impairment Hepatitis

High Cholesterol HIV/AIDS Incontinence Kidney Problems Metal Implants MRSA

Multiple Sclerosis Muscular Disease Osteoporosis Parkinsons Rheumatoid Arthritis

Seizures Smoking Speech Problems Thyroid Disease Tuberculosis Vision Problems

Other_____

What are your goals for your course of physical therapy? _____

_____

Patient Signature: _____ Date:_____