Patient name:_____ Age_____ Date:_____

Have you fallen in the last 12 months and if so, how many times? ____ No ____ Yes, _____times.
If you fell, were you injured to a degree which required medical treatment? ____No ____Yes

1. Please briefly describe the symptoms or condition you are here for today: _____
_____
_____

2. List any significant past injuries or surgeries relevant to the condition for which you are here for today (include dates):_____
_____
_____
_____

3. Have you had any tests for this condition?
☐ Yes ☐ No
☐ X-ray ☐ MRI
☐ CT/CAT Scan ☐ Nerve Conduction Test
Results:_____
_____

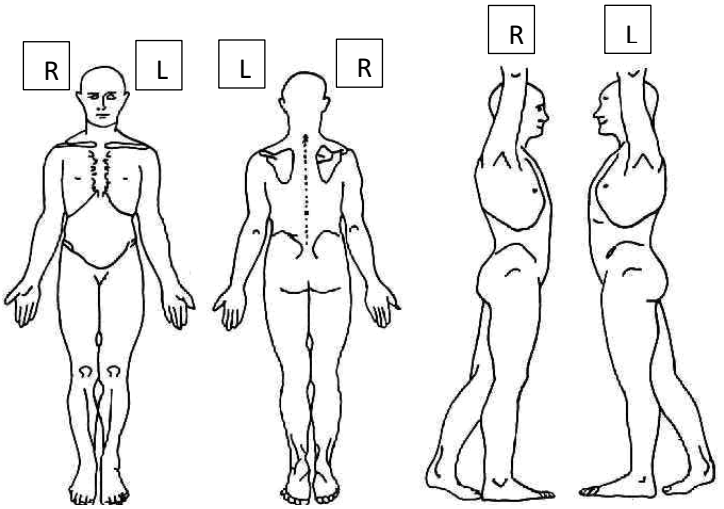
4. Do you currently have or have you had a history of the following conditions:

☐AIDS ☐Artificial Joints ☐ Heart Murmur
☐Allergies ☐Asthma ☐Heart trouble
☐Anemia ☐Cancer
☐Arthritis ☐Cardiac Pacemaker
☐High Blood Pressure ☐Psychiatric Care
☐Artificial Heart Valves ☐Diabetes
☐Stroke ☐ Pregnancy
☐Other significant health condition _____
_____

5. To your best ability, list (or provide a copy) of ALL prescription medications, over the counters, herbals, and vitamins/minerals/dietary (nutritional) supplements including name, dosage, frequency and route of administration.

_____
_____
_____
_____
_____
_____

On the body chart below, please indicate where your symptoms are.



1. On the line below, make a mark indicating your level of pain.

"0" Best "10" Worst"

2. Describe when and how your symptoms began:
_____
_____

3. What makes your symptoms worse? _____
_____

4. What makes your symptoms better?_____
_____

5. How do symptoms change over the course of the day?
For example, best in morning; worse as day progresses; etc.
_____
_____

6. Are your symptoms currently:
☐ Improving ☐ Getting worse ☐ Staying the same

7. Have you had treatment for your current condition? If so, please list and describe the results. *For example, "Steroid injection – no change."*_____
_____
_____

8. What are your goals for physical therapy?_____
_____