Patient Condition

Reason for Visit _____

When did your symptoms occur? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Pain at LOWEST: Rate your lowest pain level in the past 24-48 hours. (0=no pain 10=worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Pain CURRENTLY: Rate your level of pain at this time. (0=no pain 10=worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Pain at WORST: Rate your worst pain level in the past 24-48 hours. (0=no pain 10=worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Current Status

Which of the following describes you currently?

☐ Working; if yes:

☐ Full Duties ☐ Limited

☐ Homemaker, retired or unemployed

☐ Not Working; if yes, please explain:

_____

_____

_____

Does your job require lifting, standing, or other physical demands?

☐ Yes ☐ No

If yes, please list: _____

_____

Your Health

Please list current medications/ supplements: _____

_____

Are you currently taking blood thinning or anticoagulant medications for any medical condition? ☐ Yes ☐ No

Are you latex sensitive or allergic to latex? ☐ Yes ☐ No

Please list all allergies: _____

_____

For Women: Are you currently pregnant or think you might be pregnant?

Yes ☐ No ☐

Do you currently have any or have you recently had any of the following medical problems/ symptoms:

AIDS/ HIV	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No		
Arthritis or joint pain	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No		
Bleeding Disorder	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Anxiety/ Depression	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No		
Heart Problems	☐ Yes ☐ No	Unexplained Weight loss/ gain	☐ Yes ☐ No		
Hepatitis	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No		
High blood pressure	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No		
Muscle diseases	☐ Yes ☐ No	Worse pain at night	☐ Yes ☐ No		
Night sweats	☐ Yes ☐ No	Other: _____			

Please describe how the injury or accident occurred

_____

_____

_____

_____

_____

_____

_____

Previous Treatments & Tests

Name of the doctor that treated you FIRST for this problem:

_____

_____

What treatments did you have? _____

_____

Results _____

_____

What tests have you had

☐ CT scan ☐ MRI ☐ X-ray ☐ EMG ☐ Other

Results: _____

_____

By signing here I verify that all the information listed above is accurate. Under any falsification of date or information Weber Physical Therapy has the right to obtain compensation and retributions from the hereby signed person.

Patient Signature _____ Date: _____

Therapist Signature _____ Date: _____