MASON PHYSICAL THERAPY & WELLNESS CENTER

Name: _____ Date:_____DOB: _____

Address_____ Phone: _____ Email: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in bowel or bladder function
- ❑ nausea/vomiting
- ❑ dizziness/lightheadedness
- ❑ difficulty maintaining balance while walking
- ❑ weight loss/gain
- ❑ shortness of breath
- ❑ headaches
- ❑ changes in appetite
- ❑ fever/chills/sweats
- ❑ pain at night
- ❑ weakness/fatigue
- ❑ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer (type)_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ asthma
- ❑ pacemaker inserted
- ❑ osteoporosis
- ❑ chemical dependency (i.e., alcoholism)
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ depression
- ❑ anemia
- ❑ lung problems
- ❑ thyroid problems
- ❑ other_____
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ kidney/liver problems
- ❑ stomach ulcers
- ❑ epilepsy
- ❑ Parkinson's disease
- ❑ other_____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Do you smoke? Yes No _____ pack/day
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications:_____
Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**
ALLERGIES: _____ Are you latex sensitive? Yes No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

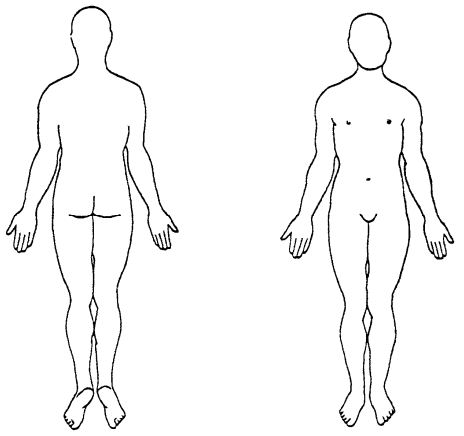
Pain at WORST: Rate your highest pain level in past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. [Circle number below]**:**

_____ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

What is your goal for therapy at this time?_____

Patient Signature_____ Date:_____

(for office use only) PT initials_____ Date_____