Welcome! Please fill this out to the best of your ability and return to the front desk. Thank you!

Date: _____ Date of Injury/Start of symptoms:_____

Reason for visit (pain, balance etc): _____

Height: _____ Weight: _____ Occupation: _____

Were you scheduled for your evaluation in a timely manner? _____ If No, how many days did it take to schedule? _____ Gender: _____

Activity	**CURRENT** Rating										
We want to know **your goals** to help us guide your care. Please list important activities that you are unable to do or are having difficulty with. ***WHAT ACTIVITIES DO YOU HAVE DIFFICULTY WITH BECAUSE OF YOUR PROBLEM?***	0 = **Unable** to perform activity										10 = **Able** to perform activity at same level as before injury or problem
List up to 3 activities below.	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.											
2.											
3.											

Currently I am experiencing (check all that apply):

- ❑Fever/chills/sweats
- ❑Numbness or Tingling
- ❑Depression
- ❑Headaches
- ❑Fatigue
- ❑Changes in bowel or bladder function
- ❑Poor balance (falls)
- ❑Changes in appetite
- ❑Shortness of breath
- ❑Nausea /Vomiting
- ❑Difficulty sleeping
- ❑Unexplained weight loss
- ❑Difficulty swallowing
- ❑Dizziness
- ❑Increased pain at night
- ❑Difficulty concentrating, thinking

Please circle any medical or surgical history we should be aware of:

- ❑Arthritis
- ❑Blood Clots
- ❑Blood disease
- ❑Cancer
- ❑Diabetes
- ❑Drug-resistant infection
- ❑Epilepsy/Seizures
- ❑Fibromyalgia
- ❑Heart Condition
- ❑Hernia
- ❑High Blood Pressure
- ❑High Cholesterol
- ❑Kidney Disease/Dialysis
- ❑Liver disease/Hepatitis
- ❑Lymphedema
- ❑Multiple Sclerosis
- ❑Spinal cord injury
- ❑Stroke/TIA
- ❑Thyroid disorder
- ❑Vision Problems
- ❑Memory Problems
- ❑Other:_____
- ❑Are you pregnant/nursing?

Do you smoke? ❑Yes No❑

Are you allergic to latex and/or adhesives? Yes/No

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Falls

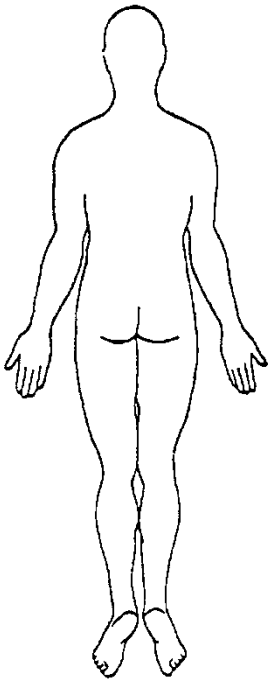
Are you worried about falling or losing your balance? _____

How many **falls or near-falls** have you had in the past 6 months? _____

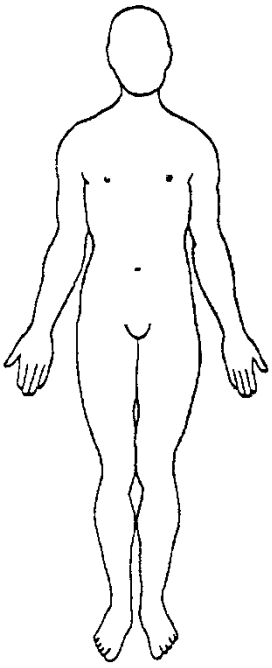
Body Chart:

On the body diagrams to the right, please mark the areas where you have symptoms:

(Left) – **Back** – (Right)



(Right) –**Front** – (Left)



Circle any that apply:

Shooting/sharp pain
Dull/aching pain
Numbness
Tingling

My symptoms currently:

❑ Come and go
❑ Are constant
❑ Are constant, but change with activity

My symptoms are worse with: _____

My symptoms are better with: _____

Please rate your pain 0-10/10 over the last couple days/weeks. 0=no pain, 10=worst pain imaginable.

Pain currently: _____
Pain at lowest: _____
Pain at highest: _____

What do you do in your free time/what are your hobbies? _____
_____

What is a realistic goal that you would like to achieve with therapy?_____
_____

Is there anything else you would like for us to be aware of?_____
_____

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