ADVANCED SPINE PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name:_____ Age:_____ Occupation:_____
Hobbies/Sports:_____Signature:_____
Referring MD:_____ Next appointment: _____
Primary MD: _____ Send copy of eval to your primary MD? Yes / No

How long have you had this problem? _____Special tests: X-ray, MRI, CT Scan,EMG
Have you had PT for this problem before. Yes / No. Have you had surgery for this problem. Yes / No.
Type of surgery _____ Date _____

Current medications, supplements, vitamins: Dosages, frequency & method of administration.

_____

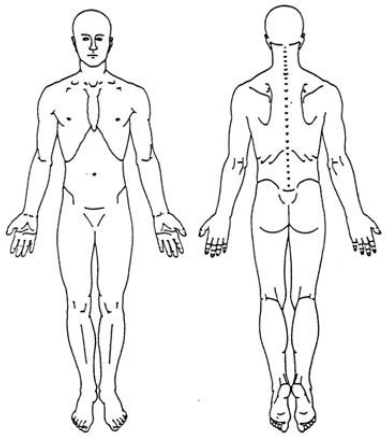
_____

Allergies, (including latex/tape) _____

Do you have or have you had any of the following conditions? (Circle any that apply.)

Lung Disease	Diabetes type 1/2	Fibromyalgia	Epilepsy/seizures	Depression/anxiety
Weakness	Hepatitis	MS	Heart Disease	Speech problems
Arthritis RA/OA	Osteoporosis	Pacemaker	Blood clots	Gall bladder problems
Hypertension	Dizziness/fainting	TMJ	Pain stim/Pump	Kidney problems
AIDS / HIV	TB	Loss of bowel control		Loss of bladder control
Lupus	Stroke / TIA	Post-polio	Parkinsons	

Pins / Implants_____ Fractures: Site_____ Date _____
Joint replacement: Site_____ Date_____ Cancer: Site_____ Date_____
Are you pregnant? Yes/No
How is your general overall health? Poor Fair Good Excellent
Have you had any falls in the last 12 months? Yes / No



PAIN ASSESSMENT

On the Body Chart, please draw the area where you have pain.
Circle the words that best describe your pain.
Constant / Intermittent. Deep / Superficial
Sharp Dull Radiating Burning Aching
Circle the level of pain that you have **today**.
(no pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (emergency room pain)

What activities are you having trouble with because of this current problem?

_____

_____

What are your goals for Physical Therapy? For example, decrease pain, increase any activity?

_____

_____

Reviewed by Therapist Signature: _____ Date: _____