

TOTAL HEALTH CENTER, INC.

Thank you for allowing us to serve you

Instructions:

Review face sheet provided and make any corrections that apply.

Fill information that applies to your particular circumstances that have led you to physical therapy.

Patient Name: _____ Email Address: _____

CURRENT CONDITION

Chief complaint: _____

Date of onset; _____

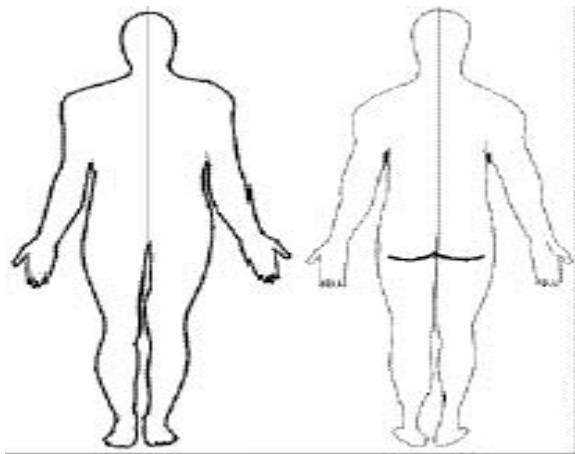
Type of injury: 1. work related, 2. non work, 3. auto, 4. fall, 5. sports, 6. post surgical

Specific Injury: _____

Treatments related to specific injury: _____

PAIN HISTORY

Please check the body part that is your concern.



On a 0-10 scale please describe your pain.

No pain is 0 Worst is 10

Pain level: today current pain level _____, best pain level _____, worse pain level _____

FUNCTIONAL STATUS – (on page 2)

Circle all that apply

(Please list the type of functional status you are now concerned with due to you current condition)

- 1. sitting to standing, 2. daily activities, which could include dressing, combing hair, putting on socks and shoes, cooking, housework. 3. working, sports activities 4. grocery shopping, 5. endurance to any activities

6. other _____

Mark the diagram at the site involved with the number(s) that apply to you.

Description: 1.aching, 2.burning, 3.deep, 4.surface, 5.dull, 6.radiates, 7.sharp, 8.stabbing, 9.stiffness

Please identify what activity if any time of day, and symptom that applies to you.

Circle all that apply

Type of activity that affects your symptoms:

- 1.bending, 2. lifting, 3. reaching, 4. running, 5.standing, 6.working, 7. walking, 8. sitting to standing, 9.laying down to sitting up,

Time of day symptoms may be worse;

Morning, afternoon, evening, night

Other Comments:

Did you take medication for pain before coming to therapy? Yes No what medication _____

(From the list of activities you are concerned about please note what best applies to your situation.) **Circle all that apply**

You are currently:

- 1. **unable** to perform the activities,
- 2. **can** perform activities with minimal difficulty.
- 3. **can** perform activities with major difficulty.
- 4. **can** perform with assistance
- 5. There is **no** concern at this time.

Are you currently working? Yes No. Last day worked _____

Did you injure yourself at work Yes No

If you are here with a workman comp case, has your physician put restrictions or limitations on you? _____

If work related, what is your occupation: _____

Type of work activity _____

MEDICAL HISTORY

Please list all surgeries you may have had, please add the year of surgery.

Please list medical Conditions that have relationship to your injury
(Include any conditions you are currently being treated for.)

Please list Pain medications the Physician prescribed related to your injury.
(Provide list of all medications you take regularly.)
