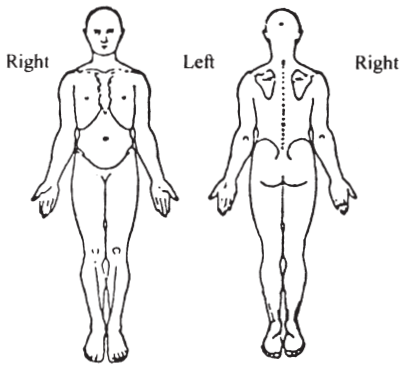
Please mark areas of pain/soreness:



PATIENT INFORMATION SHEET

Name: _____

Date: _____

Pain rating on a scale of 0 to 10 (0=no pain, 10 =worst pain imaginable):

Typical Pain: _____ Worst Pain: _____ Lowest Pain: _____

My current health is: Excellent Good Fair Poor

FUNCTIONAL QUESTIONNAIRE

Do you live (circle): Alone With someone (family, spouse, friend) Anticipated Housing _____

PLEASE CIRCLE ANY AND ALL ACTIVITIES THAT ARE AFFECTED BY YOUR PAIN OR INJURY.

- Sleeping
- Sitting
- Standing
- Bending
- Lifting
- Reaching
- Driving
- Stair Climbing
- Walking (on level surface)
- Walking (on unlevel surfaces)
- Balance
- Yard Work
- Housework
- Dressing
- Toileting
- Sports/Hobbies
- Bathing
- Eating/Swallowing
- Talking/Phone
- Work Duties
- Writing
- Computer Work
- Other: _____
- Restrictions: _____

Please list all current medications and why you're taking them:

_____

_____

PAST MEDICAL HISTORY

Heart trouble/Pacemaker? (heart attack, chest pain, arrhythmia)	yes	no	Allergies? (environmental, medicine, cortisone, latex, bees)	yes	no
Seizures?	yes	no	High Blood Pressure?	yes	no
Neurological conditions? (stroke, Parkinson's, head injury)	yes	no	Diabetes?	yes	no
			Major Accidents?	yes	no
Breathing problems? (Emphysema, Tuberculosis, Asthma)	yes	no	_____		
			Recent and Major Surgeries?	yes	no
Blood disorders (Hepatitis/AIDS)	yes	no	_____		
Broken Bones/Fractures?	yes	no	_____		
Any metal or plastic? (pins, plates, IUD, screws)	yes	no	Pregnant?	yes	no
			Any others?	yes	no
Cancer?	yes	no			

_____ Patient Signature

_____ Therapist Signature