MIDTOWN PHYSICAL THERAPY, PLLC

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NAME: _____ **DATE:**_____

DATE OF BIRTH: _____ **SOCIAL SEC. #**_____

WHAT IS YOUR PRESENT COMPLAINT:_____

WHEN AND HOW DID YOUR PROBLEM BEGIN: _____

WHAT MAKES THE PROBLEM BETTER? __NOTHING __LYING DOWN __WALKING __ STANDING __SITTING __INACTIVITY __MOVEMENT/EXERCISE

WHAT MAKES THE PROBLEM WORSE? __NOTHING __LYING DOWN __WALKING __ STANDING __SITTING __INACTIVITY __MOVEMENT/EXERCISE

HOW WOULD YOU DESCRIBE THE PAIN? __SHARP/STABBING __SHARP/DULL __ACHES __DULL __SORENESS __WEAKNESS __THROBBING/GNAWING __GRIPPING/CONSTRICTING __BURNING __TINGLING

HOW BAD IS YOUR PAIN OR PROBLEM? 0 1 2 3 4 5 6 7 8 9 10 (0=NO PAIN, 10=UNBEARABLE)

HOW IS YOUR LIFESTYLE BEING AFFECTED DUE TO THE PAIN?
_____

WHAT TIME IS THE PAIN MOST SEVERE?
_____

WHAT TIME IS THE PAIN LEASTSEVERE?
_____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? IF SO LIST TYPE OF TREATMENT RECEIVED AND CONTACT INFO FOR DOCTOR?
_____

WHAT IS YOUR OCCUPATION?
_____

HAS ANYONE IN YOUR FAMILY HAD SIMILAR COMPLAINT? (WHO, WHAT)_____

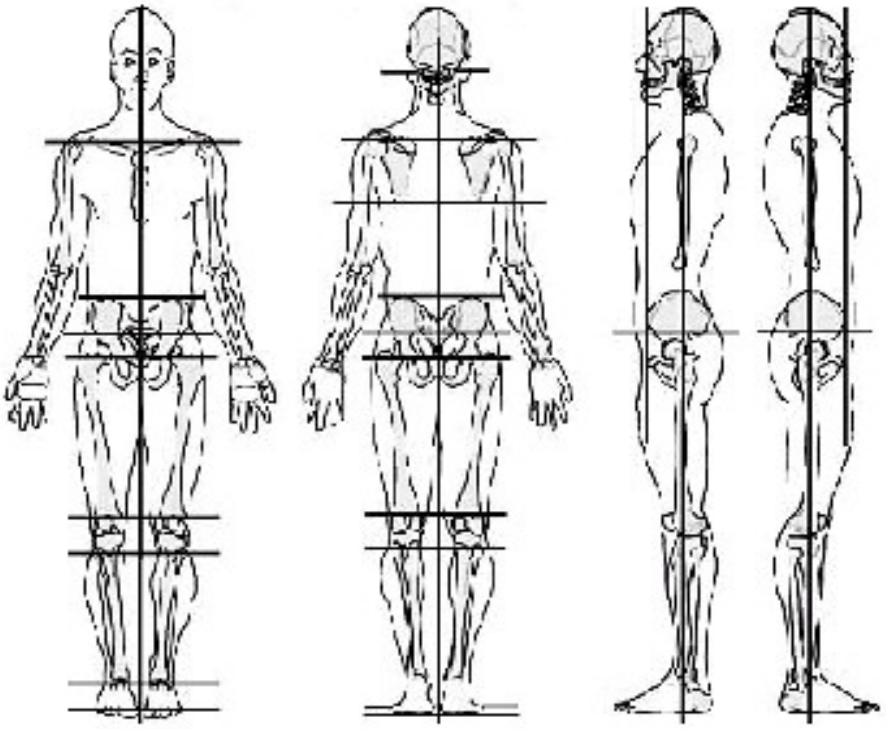
HAVE YOU EVER HAD THIS PROBLEM BEFORE? (WHEN/WHAT)
WHO IS YOUR PRIMARY CARE PHYSICIAN? (NAME, PHONE, ADDRESS)_____

ARE YOU CURRENTLY ON ANY MEDICATIONS? IF SO WHICH ONES AND FOR WHAT?
_____

HAVE YOU HAD ANY SURGERIES?_____

IS YOUR PAIN WORK OR AUTOMOBILE RELATED?_____

COLOR THE AREA ON THE MODEL WHERE YOU ARE EXPERIENCING PAIN



HAVE YOU EVER EXPERIENCED THE FOLLOWING:

STIFF NECK (IF SO WHEN?)_____

BACKACHE (IF SO WHEN?)_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

_____ HEADACHES _____ALLERGIES _____ LOSS OF SLEEP

_____ FATIGUE _____CONVULSIONS _____LOSS OR _____GAIN OF WEIGHT

_____DIZZINESS _____NUMBNESS OR _____PAIN IN ARMS, HANDS, OR LEGS

ANY PROBLEMS WITH: EYES, EARS, NOSE OR THROAT_____

_____

DO YOU WEAR GLASSES OR CONTACT LENSES? Y OR N IF YES WHY? NEAR SIGHTEDNESS OR FAR SIGHTEDNESS

CARDIOVASCULAR: DO YOU SUFFER FROM ANY OF THE FOLLOWING:

_____ RAPID BEATING HEART _____ PREVIOUS HEART STROKE

_____ SLOW BEATING HEART _____ HARDENING OF ARTERIES

_____HIGH BLOOD PRESSURE _____ SWELLING OF ANKLES

_____LOW BLOOD PRESSURE _____ POOR CIRCULATION

_____PAIN OVER HEART _____PARALYTIC STROKE

GASTROINTESTINAL: DO YOU SUFFER FROM ANY OF THE FOLLOWING:

___POOR APPETITE _____VOMITING OF BLOOD _____HEMORRHOIDS (PILES)

___DIFFICULT DIGESTION _____PAIN OVER STOMACH _____INTESTINAL WORMS

___EXCESSIVE HUNGER _____DISTENSION OF ABDOMEN _____LIVER TROUBLE

___BELCHING OR GAS _____CONSTIPATION _____GALL BLADDER TROUBLE

___NAUSEA _____DIARRHEA _____JAUNDICE

__VOMITING _____COLON TROUBLE _____COLITIS

URINARY: DO YOU SUFFER FROM ANY OF THE FOLLOWING:

_____FREQUENT URINATION _____KIDNEY INFECTION OR STONES _____PUS IN URINE

_____PAINFUL URINATION _____BED WETTING

_____BLOOD IN URINE _____INABILITY TO CONTROL URINE

FEMALE: DO YOU SUFFER FROM ANY OF THE FOLLOWING:

_____PAINFUL MENSTRUAL PERIODS

_____EXCESS FLOW

_____CRAMPS OR BACKACHE

_____LUMPS IN BREAST

_____MENOPAUSAL SYMPTOMS **ARE YOU PREGNANT? _____YES OR _____NO**

MALE: DO YOU SUFFER FROM ANY OF THE FOLLOWING:

_____ PROSTATE PROBLEMS