OrthoRehab Specialists, Inc.
Physical Therapy for the Twin Cities

Name

Date of birth Height Weight

Have you received ANY home health care in the last 30 days? Yes ☐ No ☐

Is this injury related to a car/work/school incident? Yes ☐ No ☐

Primary reason for today's visit: Right ☐ Left ☐

Injury/onset date: Cause of Injury:

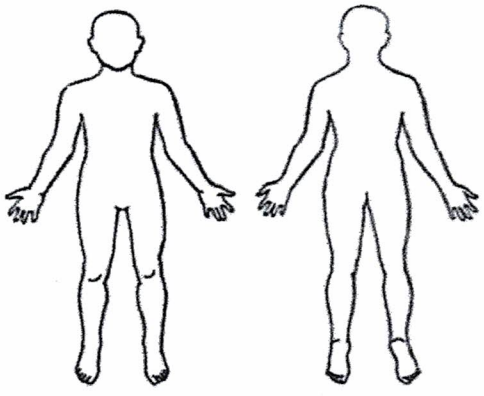
Surgery: Yes ☐ No ☐ If Yes, date: Type of surgery:

Have you had similar symptoms in the past? Yes ☐ No ☐ If yes, when?

Primary complaints and function limitations: (walking, stairs, sitting, standing, sleep, driving, bathing, dressing, cooking, etc.)

Mark or describe your area of injury on the diagram

FRONT BACK



Pain scale: 0 = none, 10 = worst pain imaginable

	0	1	2	3	4	5	6	7	8	9	10
Pain at worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain currently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain at best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Describe your pain (dull, achy, sharp, etc):

What makes your pain better?

What makes your pain worse?

What is your occupation?

Are you currently working? Yes ☐ No ☐

What are the physical requirements of your job?

Diagnostic Testing: X-ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Other ☐

Has your doctor given you any precautions/restrictions? Yes ☐ No ☐ If yes, please list _____

Have you fallen in the last year? Yes ☐ No ☐ If yes, how many times? _____

Do you have any numbness or tingling? Yes ☐ No ☐ If yes, where? _____

Do you experience pain at night, waking you from sleep? Yes ☐ No ☐

Have you had any changes in bladder/bowel function? Yes ☐ No ☐

Have you experienced any unexplained weight loss? Yes ☐ No ☐

Are you a smoker? Yes ☐ No ☐

Do you have any latex, tape, or food allergies? Yes ☐ No ☐ If yes, please list _____

Do you often get dizzy or light-headed? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Have you had physical therapy previously? Yes ☐ No ☐ If yes, for what injury?

Have you seen other heath care providers for this issue? Physician ☐ Chiropractor ☐ Podiatrist ☐ Dentist ☐ Other ☐

Have you tried any other treatments for this issue? Chiropractic ☐ Acupuncture ☐ Braces ☐ Injections ☐ Other ☐

Were previous treatments helpful? Yes ☐ No ☐

What are your physical therapy goals?

Medical History: *Have you ever been diagnosed with any of the following conditions? (check all that apply)*

Alzheimer's	Yes ☐ No ☐	Immunosuppression	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Incontinence	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Kidney disease	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Lupus	Yes ☐ No ☐
Cardiovascular/Heart Disease	Yes ☐ No ☐	Mental illness	Yes ☐ No ☐
Cauda Equina Syndrome	Yes ☐ No ☐	Multiple Sclerosis	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Muscular Dystrophy	Yes ☐ No ☐
Circulation Problems	Yes ☐ No ☐	Obesity	Yes ☐ No ☐
Current Infection	Yes ☐ No ☐	Osteoarthritis	Yes ☐ No ☐
Depression	Yes ☐ No ☐	Osteoporosis/Osteopenia	Yes ☐ No ☐
Diabetes Mellitus Type 1	Yes ☐ No ☐	Parkinson's	Yes ☐ No ☐
Diabetes Mellitus Type 2	Yes ☐ No ☐	Rheumatoid Arthritis	Yes ☐ No ☐
Emphysema/Bronchitis	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Traumatic Brain Injury	Yes ☐ No ☐
Fibromyalgia	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Fracture Or Suspected Fracture	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Hearing loss	Yes ☐ No ☐	Vision loss	Yes ☐ No ☐
Hepatitis	Yes ☐ No ☐	Other	
High Blood Pressure	Yes ☐ No ☐		
Huntington's	Yes ☐ No ☐		

Surgical History (Please list all surgeries and dates)

Please list all medications and dosages including prescription, over the counter, vitamins, and supplements

Medication	Dosage	Reason for taking	Administration (oral, topical, patch, etc)

Patient signature _____ Date _____

Therapist signature _____ Date _____

Therapist name _____ License Number _____