MAGNOLIA
Physical Therapy
Freedom From Pain

Patient Name: _____ Date: _____ Age:_____

Are you presently working? ☐ Yes ☐ No Occupation: _____

What is the main reason for your visit today? _____

Date of injury/onset: _____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury ☐ Other:

☐ Motor vehicle accident(alert DOF) ☐ Athletic / recreational injury

☐ Cause unknown ☐ Injury related to falling

Have you seen anyone else for your current condition?

☐ Physician / MD ☐ Chiropractor ☐ Podiatrist ☐ Other: _____
☐ Dentist ☐ Neurologist ☐ Physical Therapist

Have you had any diagnostic tests for you current condition? ☐ Yes ☐ No

If yes please list_____

Have you received any treatment for this condition? ☐ Yes ☐ No Have you had a related surgery? ☐ Yes ☐ No

Please list your primary care physician and/or referring physician:

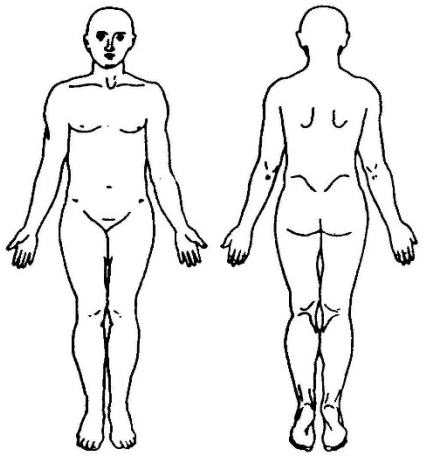
_____

Rate your **lowest** pain level in the past 24 hours. ___ / 10

Rate your pain level at this time. ____ / 10

Rate your **highest** pain level in the past 24 hours. ___ / 10

On the diagram to the right, please mark the location of your pain.



Is your pain:

☐ Sharp ☐ Piercing ☐ Aching
☐ Dull ☐ Shooting ☐ Deep
☐ Tingling ☐ Intermittent ☐ Superficial
☐ Numb ☐ Burning ☐ Stabbing

What makes your pain or symptoms worse? _____

What makes your pain or symptoms better? _____

Are your symptoms: ☐ improving ☐ worsening ☐ staying stable

Are your symptoms worse in the: ☐ morning ☐ afternoon ☐ evening ☐ inconsistent

MAGNOLIA
Physical Therapy
Freedom From Pain

What is your goal for physical therapy at this time? _____

Do you have or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Known Allergies	☐	☐
Chest pain / Angina	☐	☐	Hernia	☐	☐
High Blood Pressure	☐	☐	Intolerance to cold/heat	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐
Heart Attack	☐	☐	Metal Implants	☐	☐
Heart Palpitations	☐	☐	Dizziness / Fainting	☐	☐
Pacemaker	☐	☐	Recent Fractures	☐	☐
Headaches	☐	☐	Surgeries	☐	☐
Kidney Problems	☐	☐	Skin Abnormalities	☐	☐
Cancer	☐	☐	Nausea / Vomiting	☐	☐
Osteoporosis	☐	☐	Ringing in your ears	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Rheumatoid Arthritis	☐	☐
Urine Leakage	☐	☐	Hypoglycemia	☐	☐
Asthma / Difficulty breathing	☐	☐	Bruising / Bleeding Disorders	☐	☐
Other Lung Related Disorders	☐	☐	Recent Weight Gain or Loss	☐	☐
Liver / Gallbladder Problems	☐	☐	Changes in appetite	☐	☐
Smoking	☐	☐	Hearing Deficits	☐	☐
Stroke / CVA	☐	☐	Vision Deficits	☐	☐
Use of Assistive Device	☐	☐	Peripheral Neuropathy	☐	☐
Recent Falls	☐	☐	Pain at night	☐	☐
Autoimmune Disease	☐	☐	Fever/chills/sweats	☐	☐
Active Infections	☐	☐	Neurological Disorder	☐	☐
Infectious Disease	☐	☐	Other:		

If you have checked yes on any of the above items, please briefly explain and give approximated date:

_____

_____

Please list any medications, both prescribed and over the counter, and supplements that you are currently taking:

_____

_____

Please list any other surgeries and dates: _____

Are you pregnant or think that you might be? ☐ Yes ☐ No

Patient Initials: _____ Date: _____