Name:

Date:

Please check all the following conditions as they apply to you:

☐ Allergies	☐ Dizzy Spells	☐ MRSA
☐ Anemia	☐ Emphysema/Bronchitis	☐ Multiple Sclerosis
☐ Anxiety	☐ Fibromyalgia	☐ Muscular Disease
☐ Arthritis	☐ Fractures	☐ Osteoporosis
☐ Asthma	☐ Gallbladder Problems	☐ Parkinsons
☐ Autoimmune Disorder	☐ Headaches	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hearing Impairment	☐ Seizures
☐ Cardiac Conditions	☐ Hepatitis	☐ Smoking
☐ Cardiac Pacemaker	☐ High/Low Blood Pressure	☐ Speech Problems
☐ Chemical Dependency	☐ HIV/AIDS	☐ Strokes
☐ Circulation Problems	☐ Incontinence	☐ Thyroid Disease
☐ Currently Pregnant	☐ Kidney Problems	☐ Tuberculosis
☐ Depression	☐ Metal Implants	☐ Vision Problems
☐ Diabetes	☐ Other: Click or tap here to enter text.	

1. **Height:** **Weight:**
2. **Are you currently taking any medications?** ☐ Yes or ☐ No
   If yes. Please list dosage and reason for taking:
3. **Have you had any past surgical procedures?** ☐ Yes or ☐ No
   If yes. Please list dosage and reason for taking:
4. **Are you currently pregnant?** ☐ Yes or ☐ No
   Or have you been in the last year? ☐ Yes or ☐ No
5. **Do you smoke?** ☐ Yes or ☐ No **Do you drink alcohol?** ☐ Yes or ☐ No
6. **Have you received physical therapy previously?** ☐ Yes or ☐ No
7. **Is this work related?** ☐ Yes or ☐ No **Is this related to an auto accident?** ☐ Yes or ☐ No
8. **Please describe your injury and location of pain:**
9. **How and when did it start?**

10. **Does your current problem interfere with any of the following?**

☐ Reading	☐ Walking	☐ Reaching overhead
☐ Combing your hair	☐ Lifting a gallon of milk	☐ Writing a letter
☐ Bending over	☐ Standing	☐ sitting
☐ Climbing stairs	☐ Driving	☐ Dressing
☐ Sleeping	☐ Putting on shoes	☐ Other:

11. **Please check your level of pain:**

☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**