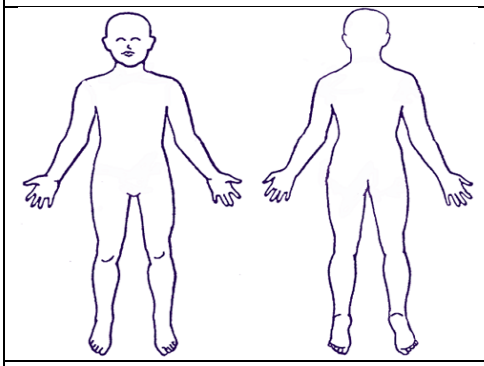
JOINT MOVEMENTS PHYSICAL THERAPY

Name:_____ **Date:**_____

Referring Physician:_____ **DOB:**_____

What is the reason for your visit today? How did your situation begin?		
When did your problem begin?		
Did you have surgery?	**YES**	**NO**
Date of surgery:		
Pain Level (at its worst): No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst		
Pain Level (at its best): No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst		
What causes your pain to increase?		



Indicate where your pain is located on the diagram & how it affects you:

Sharp	Constant (75-100%)
Dull / Achy	Moderate (50-75%)
Numbness	Intermittent (25-50%)
Burning	Minimal (0-25%)
Tingling	
Throbbing	

Patient Medical History (Please circle all that apply and add any pertinent information)

Angina / Chest Pain	Asthma	Anxiety
Cancer	Depression	Diabetes: Type I or Type II
Dizziness / Vertigo	Drug or Alcohol Dependence	Epilepsy / Seizures
Emphysema	Fibromyalgia	Hepatitis
High Blood Pressure	Joint Replacements	Bleeding Disorder / Bruising
Anemia	Pregnancy	Pacemaker
Raynaud's	Rheumatoid Arthritis	Thyroid Disorder
Systemic Lupus	Lyme Disease	Osteoporosis
Lymphedema	Swelling of Extremities	Unexplained Weight Loss

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Allergies:
Please list an previous conditions, surgeries, or hospitalizations that may have been missed above:

Please provide a list of medications that you are taking:		
Have you been treated for the current condition previously?	**YES**	**NO**
What kind of treatment did you receive?		
Have you received physical therapy this calendar year?	**YES**	**NO**
Diagnostic Tests (X-Ray; MRI; CT Scan; EMG – Date and Body Part):		
Are you currently working	**YES**	**NO**
Occupation:		
Hobbies / Sporting Interests:		
Height:	**Weight:**	
How did you hear about Joint Movements Physical Therapy?		

Signature:_____ **Date:**_____