HEALTH INFORMATION

Please check all that apply:

- ☐ CANCER OR MALIGNANCY
- ☐ DIABETES
- ☐ HEART CONDITION
- ☐ HIGH BLOOD PRESSURE
- ☐ MULTIPLE TREATMENT AREAS
- ☐ MUSCULAR DISTROPHY, HUNTINGTONS, CVA, ALZHEIMER'S, DEMENTIA)
- ☐ OBESITY
- ☐ SURGERY FOR THIS PROBLEM
- ☐ SYSTEMIC DISORDER (E.G., LUPUS, RHEUMATIOD ARTHRITIS, FIBROMYALGIA)
- ☐ ARE YOU INVOLVED IN A LAWSUIT FOR THIS CONDITION? ___YES ___NO
- ☐ MENTAL OR NERVOUS DISORDER
- ☐ BIRTH DEFECT
- ☐ ULCER OR DIGESTIVE DISORDER
- ☐ GENITO-URINARY PROBLEMS
- ☐ GOUT
- ☐ RESPIRATORY DISORDER
- ☐ CHRONIC FATIGUE
- ☐ LYMPHEDEMA

WHAT IS YOUR HEIGHT? _____

WHAT IS YOUR WEIGHT? _____

IS YOUR HEARTBEAT IRREGULAR? ___YES ___NO

DO YOU HAVE A PACEMAKER? ___YES ___ NO

DO YOU CARRY NITROGLYCERIN TABLETS? ___YES ___NO

ARE YOU PREGNANT? ___YES ___NO

ARE YOU ON MEDICATION PRESCRIBED BY A PHYSICIAN? ___YES ___NO

IF YES, PLEASE LIST YOUR MEDICATIONS:_____

_____

PLEASE LIST ANY OTHER OPERATIONS, SERIOUS ILLNESSES, ACCIDENTS OR ANY BROKEN BONES THAT YOU HAVE HAD FROM BIRTH TO PRESENT: _____

DO YOU SMOKE? ___YES ___NO **HAVE YOU GAINED OR LOST WEIGHT IN THE PAST 12 MONTHS?** ___YES ___NO

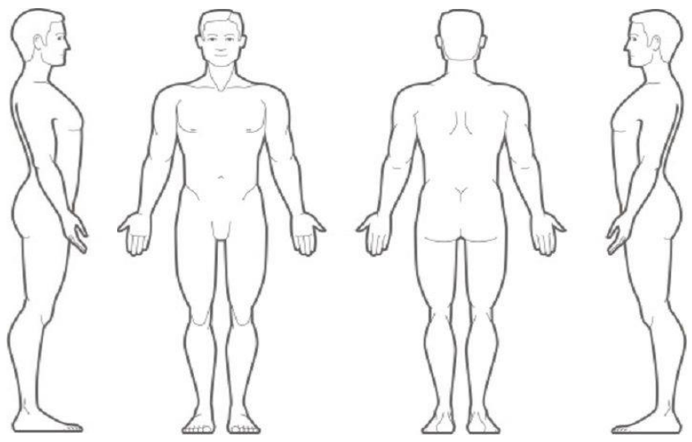
WHY ARE YOU IN NEED OF PHYSICAL THERAPY? _____

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? _____

ADDITIONAL COMMENTS AND/OR INFORMATION YOU WOULD LIKE TO ADD? _____

_____

Please mark the following diagrams/scales as they describe your pain level and function TODAY



1 2 3 4 5 6 7 8 9 10

No pain Most pain

1 2 3 4 5 6 7 8 9 10

Able to do most things Unable to do anything

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AT THE PRESENT TIME.

Signed:_____ Date: _____