VIRGINIAN
PHYSICAL THERAPY
& STAFFING

Name: _____Date: _____Primary Care Physician:_____.

**Have you RECENTLY noted any of the following (check all that apply)?**

- ❑ Changes in bowel or bladder function
- ❑ Weight loss/gain
- ❑ Fever/chills/sweats
- ❑ Nausea/vomiting
- ❑ Shortness of Breath
- ❑ Pain at night
- ❑ Dizziness/lightheadedness
- ❑ Headaches
- ❑ Weakness/fatigue
- ❑ Difficulty maintaining balance while walking
- ❑ Changes in appetite

**Have you EVER been diagnosed with any of the following conditions (Check all that apply)?**

- ❑ Cancer(type)_____.
- ❑ Rheumatoid arthritis
- ❑ Diabetes
- ❑ Heart disease
- ❑ Stroke
- ❑ Multiple sclerosis
- ❑ High blood pressure
- ❑ Depression
- ❑ Kidney/ liver problems
- ❑ Asthma
- ❑ Anemia
- ❑ Stomach ulcers
- ❑ Pacemaker inserted
- ❑ Lungs problems
- ❑ Parkinson's disease
- ❑ Epilepsy
- ❑ Osteoporosis
- ❑ Thyroid problems (Hyper / Hypo) (Circle one)
- ❑ Chemical dependency
- ❑ Other_____.

During the past month have you been feeling down, depressed or hapless? **YES** **NO**

During the past month have you been mothered by having little interest or pleasure in doing things? **YES** **NO**

**Do you Smoke?** **YES** **NO**

**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? **YES** **NO**

_____.

**Please list current medications**:_____.

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES** **NO**

**ALLERGIES:**_____ARE YOU **LATEX SENSITIVE**? **YES** **NO**

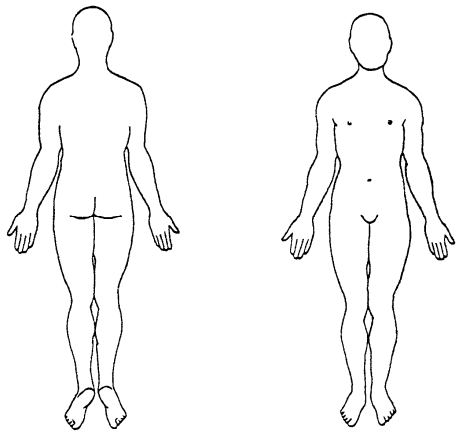
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____2._____3._____.

_____.

## Please Mark the Location of Your Pain and Type of Pain on the Chart:

Key: **X** sharp stabbing pain. **O**: Dull achy pain **….** Numb/Tingling **////** Throbbing **==** Burning



BODY CHRT

1. Pain at lowest: rate your lowest pain level in past 24 hrs

_____.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

2. Pain Currently: Rate your level of pain at this time.

_____.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

3. Pain at Worst: Rate your highest pain level in past 24 hrs.

_____.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

_____.

**List activity (important one) your are unable or have difficulty performing a result of our pain or symptoms.**

_____(ex. Stairs, walking, bending, reaching overhead)

_____.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

What is your goal of therapy at this time?_____.

**Patient signature:**_____**Date:**_____.