inmotion PHYSICAL THERAPY
BON SECOURS HAMPTON ROADS

InMotion Physical Therapy

Name: _____ **Age:** _____

Medical History (check all that apply)

					Weight Change of more than 10 lbs recently		
_____	Heart Disease	_____	Diabetes	_____	High Blood Pressure	_____	Asthma
_____	Fibromyalgia	_____	Tuberculosis	_____	Visual Impaired	_____	Epilepsy
_____	HIV/AIDS	_____	Arthritis	_____	Hearing Impaired	_____	Cancer
_____	Depression	_____	Pacemaker	_____	Latex Allergy	_____	Scoliosis
_____	Osteoporosis	_____	Thyroid problems	_____	Pregnant	_____	Stroke
_____	Ehlers-Danlos syndrome	_____	Alchohol use	_____	Tobacco use	_____	Hepatitis
_____	Multiple Sclerosis (MS)	_____	Other (please explain): _____				

Therapist's comments: _____

Have you had **surgery** for your condition? **Y** **N** If yes, please give date(s):_____

Have you had **injections** for your condition? **Y** **N** If yes, please give date(s):_____

Please list any **diagnostic tests** you have had for this condition: _____

Have you had any **previous Physical Therapy or Chiropractic treatment** for this condition? **Y** **N**

What are your current symptoms? _____

Where is your pain or problem located? _____

When did the injury or symptoms occur? _____

How did the injury or problem occur? _____

Please rate your pain using a 0-10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset _____ **Lowest** pain since onset _____ **Today's** pain _____

Is your pain? **Constant** **Intermittent**

What makes your pain/problem **better**? _____ **Worse**? _____

Is there pain present at night? **Y** **N** What position helps you sleep? _____

*** What do you hope to accomplish with therapy?** _____

Have you had any recent **falls** (within past 3 months) **Y** **N** If yes, when? _____

Do you worry about falling? **Y** **N**

What type of **non-work** activities are you involved in? _____

When are you scheduled to see your doctor again? _____

Would you like to speak with someone regarding **abuse or neglect** that you have recently experienced? **Y** **N**

Would you like to speak with someone regarding **suicide**? **Y** **N**

Employment History Are you currently working? **Y** **N** If no, how many total days of work have you missed? _____

Are your work duties **Restricted** **Full** How many hours per week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What critical work duties have been most affected by your problem? _____

To the best of my knowledge and belief, the information I have given is complete and true. Please sign below.

**** Patient Signature:** _____ ******

Therapist's comments: _____

Therapist's signature: _____ **Date:** _____ **Time:** _____