inmotion PHYSICAL THERAPY
BON SECOURS HAMPTON ROADS

InMotion Physical Therapy

Name: _____ **Age:** _____

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?** _____

Therapist's comments: _____

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? _____
How would you rate your overall health status (circle one) ? **Poor** **Fair** **Good** **Excellent**
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:** _____