EDGE Physical Therapy & Sports Medicine

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you here today? Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you ever suffered or have been told that you have:  |   |   | Have you recently experienced:  |   |   |
| High blood pressure  | YES  | NO  | Weight loss/gain  | YES  | NO  |
| Heart problems  | YES  | NO  | Pain at night  | YES  | NO  |
| Lung Problems  | YES  | NO  | Fatigue/malaise  | YES  | NO  |
| Head injury  | YES  | NO  | Difficulty sleeping  | YES  | NO  |
| Multiple sclerosis/Parkinson’s Disease  | YES  | NO  | Joint pain and/or swelling  | YES  | NO  |
| Stroke  | YES  | NO  | Urinary or bowel problem  | YES  | NO  |
| Liver problems  | YES  | NO  | Nausea and vomiting  | YES  | NO  |
| Thyroid problems  | YES  | NO  | Numbness or tingling, if yes where?  | YES  | NO  |
| Blood disorders  | YES  | NO  | Weakness in your arms or legs  | YES  | NO  |
| Diabetes (high blood sugar)  | YES  | NO  | Coordination problems  | YES  | NO  |
| Low blood sugar  | YES  | NO  | Difficulty walking  | YES  | NO  |
| Cancer  | YES  | NO  | Dizziness or loss of consciousness  | YES  | NO  |
| Arthritis  | YES  | NO  | Chest pain  | YES  | NO  |
| Osteoporosis  | YES  | NO  | Heart palpitations  | YES  | NO  |
| Circulatory or vascular problems  | YES  | NO  | Short of breath  | YES  | NO  |
| Broken bones (fractures)  | YES  | NO  | Difficulty swallowing  | YES  | NO  |
| Other orthopedic problems  | YES  | NO  | New onset of headaches  | YES  | NO  |
| Chronic pain  | YES  | NO  | Visual problems  | YES  | NO  |
| Ulcers/stomach problems  | YES  | NO  | Hearing problems  | YES  | NO  |
| Chronic migraines  | YES  | NO  |   | YES  | NO  |
| For men only:  |   |   | Do you:  |   |   |
|  Prostate disease  | YES  | NO  | Smoke  | YES  | NO  |
| For women only:  |   |   |  If yes, how much? \_\_\_\_\_\_ ppd \_\_\_\_\_\_ wkly  | YES  | NO  |
|  Pelvic inflammatory disease  | YES  | NO  | Drink alcohol  | YES  | NO  |
|  Endometriosis  | YES  | NO  |  If yes, how much? \_\_\_\_\_per day \_\_\_\_\_\_ wkly  | YES  | NO  |
|  Complicated pregnancies  | YES  | NO  | Any significant family historyof illness or disease  | YES  | NO  |
|  Trouble with your period  | YES  | NO  | Other  | YES  | NO  |
|  Are you pregnant?  | YES  | NO  |   | YES  | NO  |

Please explain any YES answers here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had surgery or been hospitalized in the past? YES or NO

Date/reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any scars? (other than surgeries listed above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary physician that you see most often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pain Level: 0 = No Pain 10 = Extreme pain

26. Please rate your *current* pain

0 1 2 3 4 5 6 7 8 9 10

27. Please rate your *worst* pain in the last week

0 1 2 3 4 5 6 7 8 9 10

28. Please rate your *least* pain in the last week

0 1 2 3 4 5 6 7 8 9 10

*Please shade the areas where you are having pain.*

Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_