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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATION LIST: Dosage: MEDICATION LIST: Dosage:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

EDGE Physical Therapy & Sports Medicine

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

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

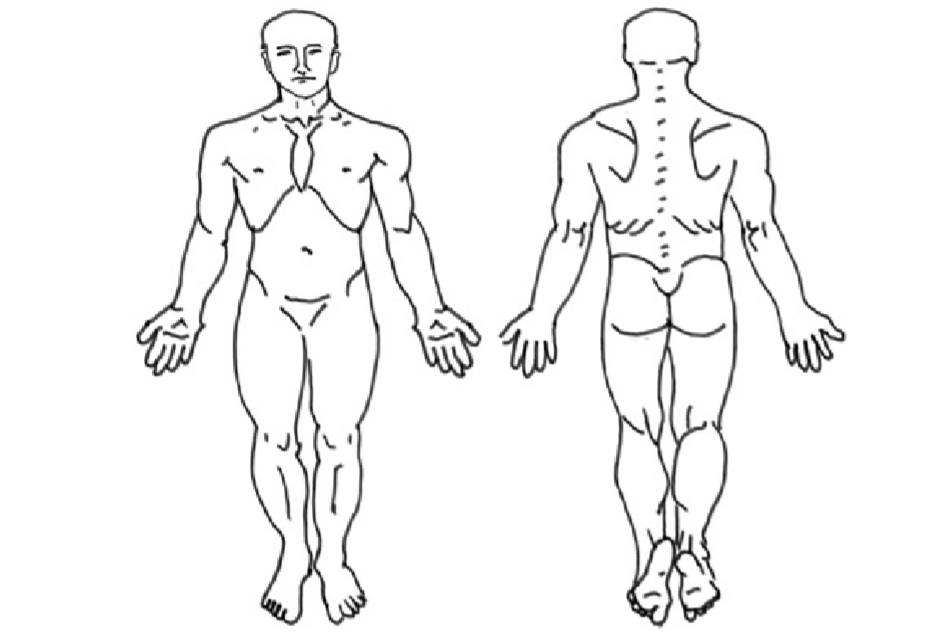
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_