REVOLUTION
PHYSICAL THERAPY

Date:
Name:_____
Birthdate:
Gender: M F Age:
Smoker: Y/ N Pregnant: Y/N
Occupation:

List all past surgeries or major injuries:

List all current medications:

Have you had an X-ray, MRI or other imaging study? Y/N

Past Medical History: Please circle each condition that you have been told you have (or had):

Osteoporosis Rheumatoid Arthritis Sexually Transmitted Disease Allergies/Asthma

Do you take blood thinners? YES/NO

Have you had recent illness?(explain if yes)

Currently I am experiencing (circle all the apply):

Changes in bowel or bladder function Changes in appetite Poor balance (falls) Dizziness

Fever/chills/sweats Unexplained weight loss Nausea/Vomiting Increased pain at night

Contributing Factors:

Have you recently experienced increased stress in your life? YES/NO If yes, please explain

How many hours do you sleep each night?

Do you take a sleeping aid? YES/NO If yes, please list medications

Describe your diet. What does a usual day of food look like for you?

Are you interested in improving your exercise, nutrition, or sleep habits? YES/NO If yes, please specify

Body Chart: Please mark the areas where you feel pain on the chart to the right.

Using the scale below, rate your pain over the last 24 hours. **0 means no pain, 10 means worst imaginable**

0 1 2 3 4 5 6 7 8 9 10

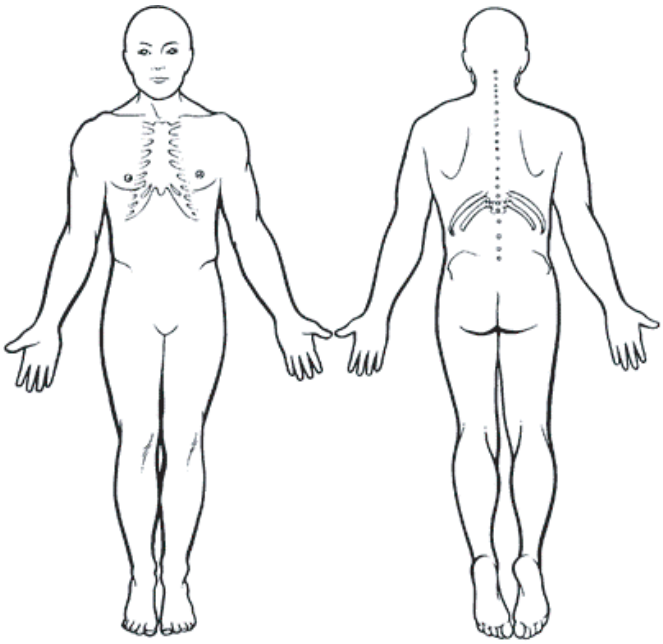
Average Pain for last 24 hours: _____
Worst Pain for last 24 hours: _____ Best
Pain for last 24 hours:

What makes your pain feel better?

Does eating change your pain? Y/N

Does going to the bathroom change your pain? Y/N

Does physical activity change your pain? Y/N



Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your symptoms. Please circle the number below which best represents your overall average level of function.

Activity #1: _____
(Completely Unable) 0 1 2 3 4 5 6 7 8 9 10 (Completely Able)

Activity #2: _____
(Completely Unable) 0 1 2 3 4 5 6 7 8 9 10 (Completely Able)

Activity #3: _____
(Completely Unable) 0 1 2 3 4 5 6 7 8 9 10 (Completely Able)

Goals:

What is your goal(s) for physical therapy?

What is your performance goal(s)?

How can we help you reach those goals?

"I should not do physical activity which might make my pain worse."

Completely Agree

Agree Somewhat

Agree Neutral

Somewhat Disagree

Completely Disagree