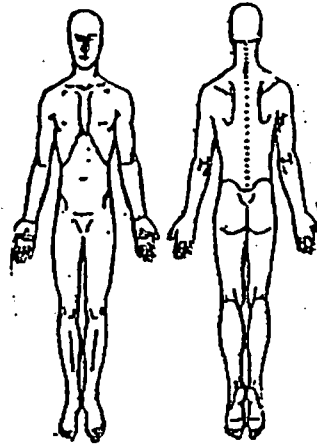




On the diagram please draw or depict your pain:



**General Medical**

Check if you have ever been diagnosed with any of the following conditions:

- |  |  |
|--|--|
| <input type="checkbox"/> Parkinson's Disease                   | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Cancer, what type _____               | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Heart problems                        | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> High blood pressure                   | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Kidney disease        |
| <input type="checkbox"/> Emphysema                             | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Chemical dependency (alcohol or drug) | <input type="checkbox"/> Epilepsy              |
| <input type="checkbox"/> Thyroid problems                      | <input type="checkbox"/> Insomnia              |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Constipation/diarrhea |
| <input type="checkbox"/> Rheumatoid arthritis                  | <input type="checkbox"/> Dementia              |
| <input type="checkbox"/> Other arthritic problems              | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Other                                 |  |

Doctor you are seeing for these conditions \_\_\_\_\_

Please list any surgeries or injuries (fractures, dislocations, sprains, etc.) for which you have been treated or hospitalized. Include approximate dates.

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Please list or attach all prescription and over-the-counter medications you are currently taking.

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What are the most important things you hope to accomplish with physical therapy?

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_