Name: ______________________**DOB:**____________ **Primary Care Physician:** _______________________

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in bowel or bladder function
- ❑ weight loss/gain
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ shortness of breath
- ❑ pain at night
- ❑ dizziness/lightheadedness
- ❑ headaches
- ❑ weakness/fatigue
- ❑ difficulty maintaining balance while walking
- ❑ changes in appetite
- ❑ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer _______________
- ❑ rheumatoid arthritis
- ❑ diabetes
- ❑ heart disease
- ❑ stroke
- ❑ multiple sclerosis
- ❑ high blood pressure
- ❑ depression
- ❑ kidney/liver problems
- ❑ asthma
- ❑ anemia
- ❑ stomach ulcers
- ❑ pacemaker inserted
- ❑ lung problems
- ❑ epilepsy
- ❑ osteoporosis
- ❑ thyroid problems
- ❑ Parkinson's disease
- ❑ chemical dependency (i.e., alcoholism)
- ❑ other_________________

Do you smoke? Yes No ______ pack/day

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list current medications:____

ALLERGIES: ____ **Are you latex sensitive?** Yes No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ______________________ **2.**_________________________ **3.**______________________________

Pain Description: How would you describe your pain?

Sharp/Stabbing **Dull/Achy** **Throbbing**

Tingling **Burning**

Pain Currently: Rate your level of pain at this time

(0 = no pain, 10 = Worst pain imaginable)

____

0 1 2 3 4 5 6 7 8 9 10

Pain LOWEST: Rate you lowest pain level in past 24 hrs (0 = no pain, 10 = Worst pain imaginable)

____

0 1 2 3 4 5 6 7 8 9 10

Pain Highest: Rate you highest pain level in the last week

(0 = no pain, 10 = Worst pain imaginable)

____

0 1 2 3 4 5 6 7 8 9 10

List 2 important activities you are unable to, or have difficulty performing due to your pain. (ex. Stairs, reaching overhead, running)

1. ____. **2.** ____

What is your goal for therapy at this time?_______________________________________

Patient Signature____ **Date:**____________________