JOHNSTON PHYSICAL THERAPY
AND SPORTS MEDICINE

Name: ____ **Date:**__________________

Physicians/Providers Involved In Your Care: ____

How did you hear about us? (Please check appropriate box) □ Physician □Friend □Facebook □Google □Internet □Johnston Living magazine □Driving by □Newsletter □Other____________

Describe the Reason You Are Here:

____

Date Symptoms Began or Date of Surgery:____

List Medications/Supplements You Are Currently Taking (and reason why):_______________________

____

Allergies: ____

Tobacco Use: Yes/No_______ **Amount/Day** ________ **Are you currently pregnant?** Yes □ No □

Have you had any imaging (MRI, CT scan, X-ray)? Yes □ No □

If yes, what were the results?____

PAIN RATING: 0-10 WITH "0" AS NO PAIN AND "10" AS NEEDING TO GO TO THE EMERGENCY ROOM

Please circle your **HIGHEST pain level

0 1 2 3 4 5 6 7 8 9 10

During what activity is your pain at its highest?

____

Please circle your **CURRENT pain level

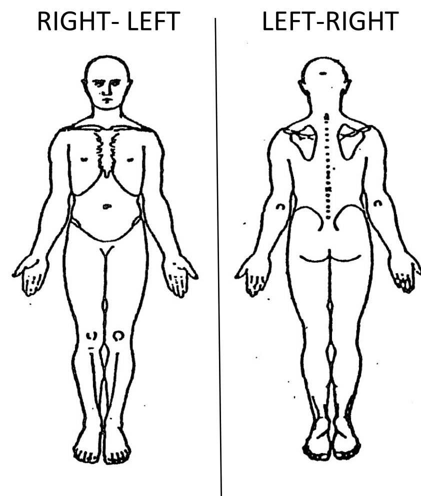
0 1 2 3 4 5 6 7 8 9 10

Please circle your **MINIMAL pain level

0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram to the right the location of your pain by marking the area with the type of pain you are experiencing: →

(X) Sharp (+) Numb/Tingling (#) Ache (B) Burning



In the past week have your symptoms:

Worsened □ **Stayed the Same** □ **Improved** □

What activities are you having difficulty performing due to your pain/symptoms? (Ex: walking, running, stairs, sitting, standing, etc.)____

____

What goals do you have for physical therapy (ex: activities to return to)_________________________

____

____

Do you exercise? Yes □ No □

If yes, what modes of exercise and how often? ____

Have you had two or more falls in the past year? Yes □ No □

Have you had a fall in the past year that has resulted in an injury? Yes □ No □

PLEASE CHECK ALL THAT APPLY:

SURGERIES	YES	NO
Joint Replacements	☐	☐
Orthopedic Surgery	☐	☐
Heart Surgery	☐	☐
Fracture Reductions, Joint Manipulations	☐	☐
Spinal Surgeries	☐	☐
Other Surgeries/Conditions	☐	☐

Please explain any item that was checked “YES”: ____

____
____
____

CONDITION	**YES**	**NO**	**CONDITION**	**YES**	**NO**
Alzheimer’s	☐	☐	Headache/Migraine	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Anxiety	☐	☐	History of Cancer	☐	☐
Bladder/Bowel Disorder	☐	☐	Huntington’s	☐	☐
Blood Clots/Vascular	☐	☐	Immunosuppression	☐	☐
Cardiovascular Disease	☐	☐	Low Blood Pressure	☐	☐
Cauda Equina Syndrome	☐	☐	Lupus	☐	☐
Current Infection	☐	☐	Muscular Dystrophy	☐	☐
Cerebral Vascular Accident	☐	☐	Obesity	☐	☐
Depression	☐	☐	Osteoarthritis	☐	☐
Diabetes Mellitus Type 1	☐	☐	Pacemaker	☐	☐
Diabetes Mellitus Type 2	☐	☐	Parkinson’s	☐	☐
Dizziness/Blackouts	☐	☐	Rheumatoid Arthritis	☐	☐
Fibromyalgia	☐	☐	Seizures	☐	☐
Fracture or Suspected Fracture	☐	☐	Traumatic Brain Injury	☐	☐

Other: ____

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____
____