CUTTING EDGE
PHYSICAL THERAPY
Sports and Life Performance

Name: _____ **Birth Date:** _____

Age:_____ **Gender:** ❑M ❑F **Weight:** _____**Height:** _____ **Dominant Hand:** ❑**Right** ❑**Left** ❑**Both**

Emergency Contact: _____ **Phone#:** _____

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

❑ cancer	❑ depression	❑ heart problems	❑ lung/respiratory problems
❑ diabetes	❑ stroke	❑ osteoporosis	❑ high blood pressure
❑ multiple sclerosis	❑ rheumatoid arthritis	❑ osteoarthritis	❑ blood clots

Are you latex sensitive? ❑**Yes** ❑**No** **Do you smoke?** ❑**Yes** ❑**No** **Do you have a pacemaker?** ❑**Yes** ❑**No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑**Yes** ❑**No**

What is your reason for attending therapy? _____

What date (roughly) did your present symptoms start?_____

How did the injury/problem occur? _____

Treatment received so far for this problem (chiropractic, injections, etc) _____

Have you previously had physical therapy for this condition? ❑**Yes** ❑**No Date:** _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

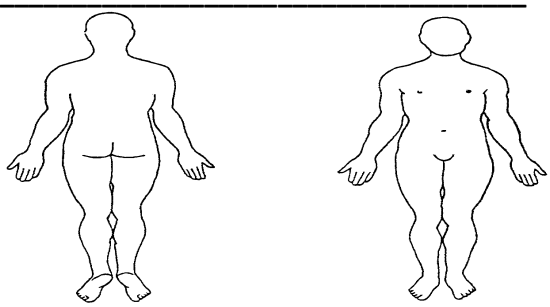
Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Are you on a work restriction from your doctor? ❑**Yes** ❑**No**

Body Chart: Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



BACK **FRONT**

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____ 2. _____ 3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____ 2. _____ 3. _____

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

When are you scheduled to see your doctor again? _____

What are you goals regarding physical therapy? _____

_____ _____

Patient Signature **Date**