



**ILLNESS OR ONSET OF PAIN INFORMATION: (required)**

ILLNESS    INJURY                      Date of Injury/Onset of Symptoms: \_\_\_\_\_  
What body part is involved: \_\_\_\_\_    Left       Right  
Injury Occurred:  Home    Employment\*    School\*    Recreation\*    Pedestrian\*    MVA/Auto\*  
 Other – Briefly explain: \_\_\_\_\_

**\*If this is a Workers Comp/Liability/Auto Claim - Please Complete Section Below**

Name of Workers Compensation/Liability/Auto Insurance: \_\_\_\_\_  
State that incident occurred in: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Insurance Adjusters Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Extension Number: \_\_\_\_\_  
Has an Attorney been obtained:  Yes    No – If yes please complete below  
Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**    Newspaper    Past Patient/Friend    Medical Doctor    Website  
 Yellow Pages    Other \_\_\_\_\_

**MEDICAL HISTORY**

Please rate your pain using a 0-10 pain scale – (0= No pain; 10= The worst pain that you can imagine)

**Current Pain:** \_\_\_\_\_      **Least Pain:** \_\_\_\_\_      **Worst Pain:** \_\_\_\_\_

Are your symptoms getting – **worse** – **better** – **staying the same** – since your onset of symptoms?

**Please check any medical conditions that we should be aware of:**

____ High Blood Pressure	____ Scoliosis/Back Disorder	____ Heart Attack/Heart Problems
____ Diabetes	____ Lung Disorders	____ Blood Disorders
____ Cancer	____ Ulcer/Digestive	____ Arthritis
____ Metal Implants	____ Pacemaker	____ Seizure Disorder
____ Hepatitis C	____ Tuberculosis	____ Vertigo

**Are you Pregnant ?**    yes       no

Any Other Conditions/Concerns that we should be aware of?: \_\_\_\_\_

Surgeries and Surgical Dates: \_\_\_\_\_

Please list all medications you are taking (Prescription and Over the Counter): \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Have you had any diagnostic testing performed related to your current injury?

MRI    X-ray    CT Scan    EMG    None    Other:

**To the best of my knowledge, the information that I have given is complete and true.**

**Patient/Guardian Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_