Yellowstone Physical Therapy

Name:______________________________

Referring Physician:__________________

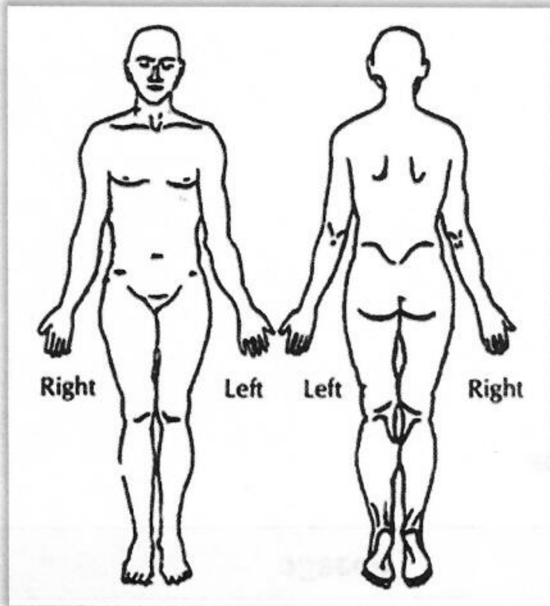
Diagnosis, if known:__________________

Date of Injury and/or Surgery:__________

Due to Motor Vehicle or Work?_________

Height:________ Weight:_____________

Mark your area of pain on the body below and circle your level of pain on the scale to the right.



	Scale
No pain	0
	1
Mild, annoying pain	2
	3
Nagging, uncomfortable, troublesome pain	4
	5
Distressing, miserable pain	6
	7
Intense, dreadful, horrible pain	8
	9
Worst possible, unbearable, excruciating pain	10

Surgeries, injuries, prior physical therapy (Please Include Dates)

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-
-
-

Relevant medical history (any bone & joint problems, high blood pressure, cancers, diabetes, strokes, etc.)

-
-
-
-

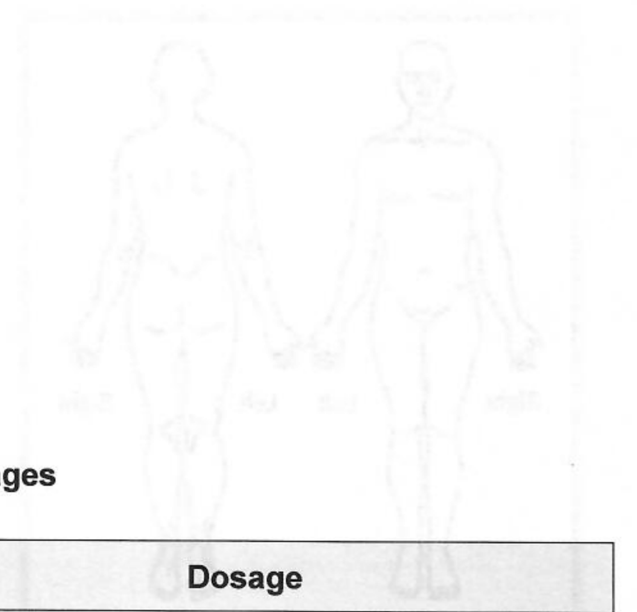
Have you fallen in the past six months? Yes ☐ No ☐ If yes, how many times?_________

Do you have a **pacemaker** ☐, **defibrillator** ☐ or **metal implants** ☐ ? (Check all that apply)

Do you have allergies or skin sensitivities to tape, adhesives or latex? **Yes** ☐ **No** ☐

****All fields required****

Continued on reverse side →



Medications & Dosages

Medication	Dosage