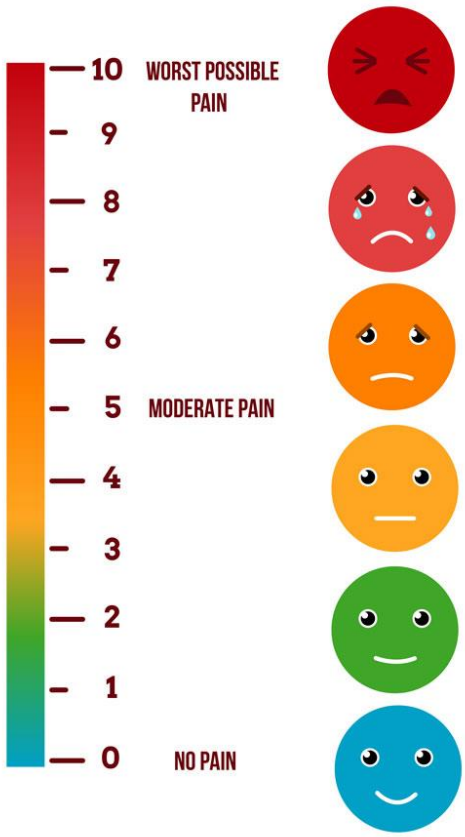
Name _____

Circle your level of pain below



Date _____

Primary Care Provider _____

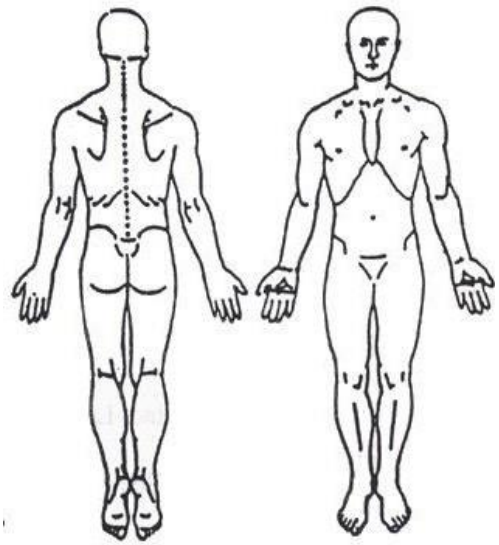
Diagnosis, if known _____

Date of Injury or Surgery _____

Due to Motor Vehicle Accident or Work? _____

Height _____ Weight _____

Mark your area of pain on the body below



Past surgeries, injuries, prior physical therapy (please include approx. dates)

-
-
-

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

-
-
-

Have you fallen in the last 6 months (please circle one) YES NO If yes, how many times? ___

Do you have a PACEMAKER □, DEFIBRILLATOR □ or METAL IMPLANTS □? (check all that apply)

*ALL FIELDS REQUIRED FRONT AND BACK**

Do you have allergies or skin sensitivities to tape, adhesives, or latex? YES NO

Medications & Dosages

Medication	Dosage / Frequency

Is there anything else you think we should know about why you are being seen today?

_____

_____

_____

_____

_____

_____

_____

_____

*ALL FIELDS REQUIRED FRONT AND BACK**