Core Physical Therapy

REASON FOR VISIT

________________________	________________________	________________________
First Name	Last Name	Today's Date

What is your Occupation: ____

QUESTION FOR MEDICARE PATIENTS ONLY

Are you receiving service from a Home Health Care Agency, Visiting Nurses Association, or residing in a skilled nursing facility? ☐No ☐Yes

If yes, please explain. ____

ALL PATIENTS, PLEASE CONTINUE ANSWERING THE FOLLOWING:

Reason for today's visit: ☐Emergency ☐New injury ☐Old injury ☐Chronic pain ☐Wellness

Are you in pain? ☐No ☐Yes

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

Your current level of pain while completing this survey:

☐10 ☐9 ☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1

The worst your pain has been during the past week:

☐10 ☐9 ☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1

The best your pain has been during the past week:

☐10 ☐9 ☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1

Did your injury/issue occur during:

☐ Auto Accident ☐ Sports/play ☐ Work ☐ Routine/Household activity ☐ Chronic ☐ Unknown

Date your condition/accident began? ______________________________

Please explain what happened or how symptoms began: __________________________________

____

Are your symptoms currently: ☐ Getting Worse ☐ Getting Better ☐ Staying about the Same

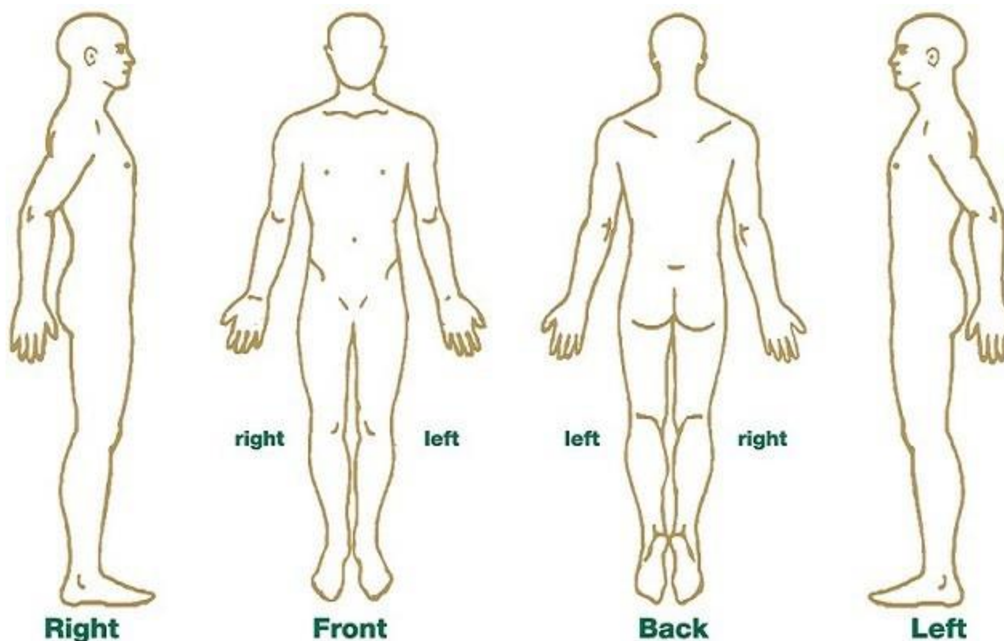
Is your condition interfering with your: ☐ Daily Routine ☐ Sleep ☐ Work ☐ None of these

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain

☐ Sleep only with medication

Please mark on the diagram the area(s) where you experience symptoms.



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List three positions or activities that make your symptoms worse: _____________________

____

When do your symptoms feel worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

List three positions or activities that make your symptoms better: ______________________

____

When do your symptoms feel best?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Symptoms currently:

☐ Are constant, but change with activity/position ☐ Are constant ☐ Come and go

Has this or something similar happened in the past? ☐ No ☐ Yes

If you have experienced this condition in the past, when? _____________________________

What treatment did you receive for this PAST condition? ______________________________

What treatment do you think your symptoms responded to best? _______________________

How long did it take you to feel better? ____

Have you had tests performed for this condition? ☐ No ☐ X-rays ☐ MRI ☐ Bloodwork

☐ Other ____________________

Have any of the following professionals evaluated or treated your condition?

☐ MD/DO/PA/ARNP ☐ Chiropractor ☐ Acupuncturist ☐ Massage Therapist

☐ Physical Therapist ☐ Other

Have you had injections or steroid medications for your condition? ☐ No ☐ Yes

Are you taking medications for your symptoms? ☐ No ☐ Yes

Have you ever had physical therapy before? ☐ No ☐ Yes

Were you happy with your previous physical therapy experience? ☐ No ☐ Yes