Cutting Edge
Physical Therapy

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: ___________________________ Date: _________________ Age: _____________
Occupation: ____

Is this an injury?
Worker's Compensation injury ____Yes ____No
MVA (Auto Accident) ____Yes ____No

Are you working with a lawyer for this injury/condition?
____Yes ____No

Are you currently: (Please Check One)
____a. Working at your usual job without restrictions
____b. Working at your usual job with restrictions
____c. Retired/Unemployed
____d. Unable to work because of other medical reasons
____e. Unable to work because of your condition

When did your current condition begin?
Month __________Day_________ Year_________
Surgery? ____Yes ____No Date:___________________

What originally caused your current symptoms? (Please Check One)
____a. Not sure of the cause
____b. Fall/Slip
____c. Motor Vehicle Accident
____d. Bend/twist
____e. Cough/Sneeze
____f. Lifting
____g. Yard Work
____h. Athletic Activity
____i. Shoveling Snow
____J. Other___________________________

PAIN INTENSITY: 0= No Pain 10= Emergency Room
At its Best 0-10 ______________
At its Worst 0-10 ____________
Now 0-10_______________

ALLERGIES: List any medication(s) you are allergic to: _______________________________________
Are you latex sensitive? ____Yes ____No
List any other allergies we should know about: ____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? _____Yes _____No

Please check any of the following whose care you are under:
____Medical Doctor (MD)
____Psychiatrist/psychologist
____Osteopath (DO)
____Dentist
____Chiropractor
____Other___________________

Have you had:
____X-rays
____MRI
____CT Scan
____Other Studies

Have YOU ever been diagnosed as having any of the following conditions?

Cancer ____Yes ____No Kind___________
High Blood Pressure ____Yes ____No
Asthma ____Yes ____No
Chemical Dependency ____Yes ____No
Diabetes ____Yes ____No
Rheumatoid Arthritis ____Yes ____No
Other Arthritis Conditions ____Yes ____No Kind___________
HIV/AIDS ____Yes ____No
Stroke ____Yes ____No
Anemia ____Yes ____No
Epilepsy ____Yes ____No
Heart Problems ____Yes ____No
Circulation Problems ____Yes ____No
Emphysema/Bronchitis ____Yes ____No
Thyroid Problems ____Yes ____No
Multiple Sclerosis ____Yes ____No
Depression ____Yes ____No
Hepatitis ____Yes ____No
Tuberculosis ____Yes ____No
Kidney Disease ____Yes ____No
Osteoporosis ____Yes ____No
Other________________

Has ANYONE IN YOUR IMMEDIATE FAMILY (parents, brothers, sisters) ever been treated for any of the following?

Diabetes	____Yes	____No	Cancer	____Yes	____No
Tuberculosis	____Yes	____No	Arthritis	____Yes	____No
Heart Disease	____Yes	____No	Anemia	____Yes	____No
High Blood Pressure	____Yes	____No	Headaches	____Yes	____No
Stroke	____Yes	____No	Epilepsy	____Yes	____No
Kidney Disease	____Yes	____No	Mental Illness	____Yes	____No
Chemical Dependency	____Yes	____No			

Have you recently noted the following?

Weight Gain/Loss	____Yes	____No	Nausea/Vomiting	____Yes	____No
Fatigue	____Yes	____No	Weakness	____Yes	____No
Fever/Chills/Sweats	____Yes	____No	Numbness or Tingling	____Yes	____No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? _____Yes _____No

If you have been under the care of a physician during the past three months, please describe for what reason (illness, medical condition, physical, etc.:____

____

Please list any injuries, surgeries, or other conditions you have treated or hospitalized for, including the approximate date, side and reason for the treatment:

DATE	**REASON FOR INJURY/SURGERY/HOSPITALIZATION**
1. __________	______________________________________
2. __________	______________________________________
3. __________	______________________________________
4. __________	______________________________________

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ______________________________	4. ______________________________
2. ______________________________	5. ______________________________
3. ______________________________	6. ______________________________

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Tylenol	____Yes	____No	Aspirin	____Yes	____No
Advil/Motrin/Ibuprofen	____Yes	____No	Laxatives	____Yes	____No
Decongestants	____Yes	____No	Antihistamines	____Yes	____No
Antacid	____Yes	____No	Vitamins/Minerals	____Yes	____No

Other________________

How often do you:	Daily	Frequently (1-3x/wk)	Occasionally 1-3x/mos)	Never
Drink caffeinated drinks/coffee	______	______	______	______
Smoke cigarettes	______	______	______	______
Drink alcohol	______	______	______	______
Use illegal substances	______	______	______	______

____ ____

Patient Signature Date Therapist Signature Date