

**Current Medical Condition**



**Personal Demographic Information:**

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe what brings you in to Physical Therapy today \_\_\_\_\_

Referring Physician \_\_\_\_\_

Date and type of surgery (if applicable) \_\_\_\_\_

**Current medical history:** Please circle any appropriate health condition that you are currently experiencing

- Weakness      Swelling      Vertigo/Dizziness      Fatigue      Changes in bowel/bladder function
- Pregnancy      Infections      Weight loss/gain      Joint Pain      Depression/Anxiety
- Shortness of Breath

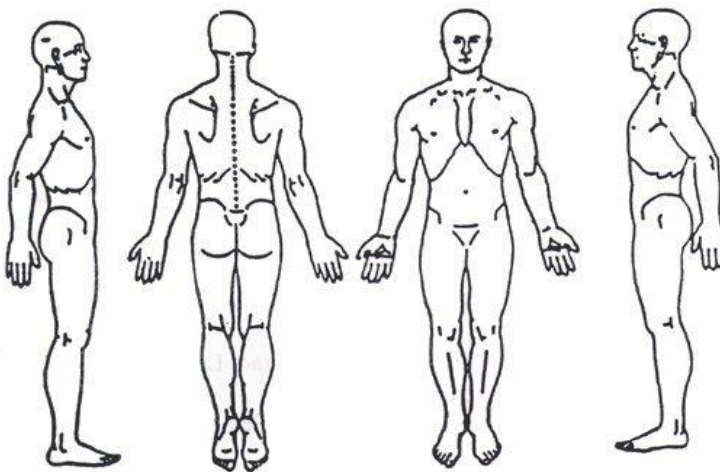
**Have you fallen in the past year? If yes, how many times?** \_\_\_\_\_

**Are you currently a smoker?** (Yes/No)

**During the past month, have you often been bothered by feeling down, depressed, and/or hopeless?** (Yes/No)

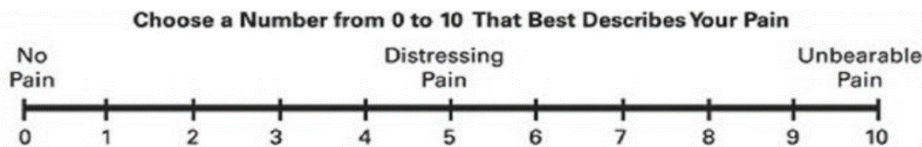
**During the past month, have you often been bothered by little interest or pleasure in doing things?** (Yes/No)

**Symptom chart:** Please identify on the figure below where you are experiencing pain



**Symptom legend:** use the symbols below to describe the quality of your pain

- ⊗ General pain
- // Numbness/Tingling



**What aggravates the pain?** \_\_\_\_\_

**What eases the pain?** \_\_\_\_\_