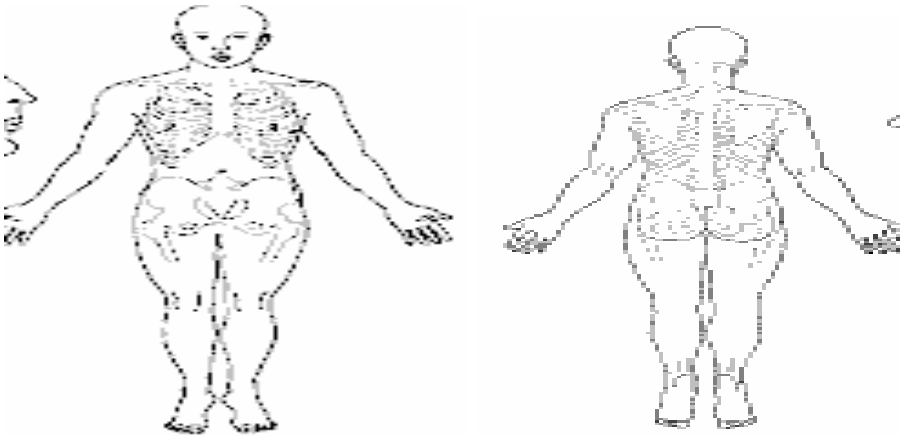
OPTIMUM CARE THERAPY
PHYSICAL THERAPY, CHIROPRACTIC SERVICES & SPORTS MEDICINE

PHYSICAL THERAPY INFORMATION

NAME:_____ AGE:_____ DATE:_____
REASON FOR THERAPY:_____
_____
DESCRIBE HOW YOUR PROBLEM BEGAN:_____
_____
HAVE YOU EVER HAD THERAPY FOR THIS BEFORE? □YES □NO
IF YES, WHAT TREATMENT DID YOU GET?_____
WAS THE TREATMENT HELPFUL? □YES □NO
NAME OTHER TREATMENT OR EQUIPMENT YOU RECEIVED FOR THIS PROBLEM_____
_____
ARE YOU CURRENTLY WORKING? _____IF NO, ARE YOU CURRENTLY NOT ABLE TO WORK BECAUSE OF YOUR INJURY?_____WHAT ARE THE PHYSICAL DEMANDS OF YOUR JOB?_____
WHAT ARE YOUR HOUSEHOLD ACTIVITIES? _____
LIST ANY HOBBIES THAT YOU ARE UNABLE TO PARTICIPATE DUE TO YOUR INJURY? _____
HAVE YOU HAD SURGERY FOR THIS INJURY? _____TYPE OF SURGERY/DATES:_____
ARE YOU CURRENTLY TAKING ANY PRESCRIBED OR NON-PRESCRIBED MEDICATIONS? □YES □NO
PLEASE LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING:_____
_____

PAIN QUESTIONNAIRE:

PLEASE SHADE ON THE DIAGRAM BELOW THE LOCATION OF YOUR PROBLEM/PAIN.



PLEASE DESCRIBE YOUR PAIN:

□DULL □SHARP □DULL ACHING □SHOOTING □THROBBING □CONSTANT □INTERMITTENT
□OTHER_____

Pain Rating: Please rate your pain using the numeric scale listed below.

*A rating of **"0"**means you have no pain at all.

*A rating of **"10"** means that your pain is unbearable and you should go to the Emergency Room immediately.

PLEASE RATE YOUR PAIN AT THE PRESENT TIME:

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Very Painful		Intense Pain-Go to ER	

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PHYSICAL THERAPY INFORMATION

PREVIOUS MEDICAL CARE (PLEASE CHECK):
□General Practitioner □Chiropractor □Occupational Therapy □Physical Therapy □Neurologist □Orthopedist
MEDICAL EXAM (PLEASE CHECK):
□CT Scan □EMG/NCV □MRI □X-Rays □Myelogram □Podiatrist □Emergency Room Care
MEDICAL HISTORY (PLEASE CHECK): Do you now have, or have you ever had, any of the following?
□Asthma, Bronchitis, or Emphysema □Shortness of Breath/Chest pain □Coronary Heart Disease or Angina
□Pacemaker □High Blood Pressure □Heart Attack/Surgery □Blood clot/emboli □Stroke/TIA □Allergies
□Pins or Metal Implants □Joint replacement (any) □Diabetes □Infectious diseases
□Cancer/Chemotherapy/Radiation □Cigarette/Tobacco use □Night sweats □Dizzy spells
□Seizures □Circulation problems □Psychiatric problems
MEDICAL SYMPTOMS

_____

_____

Additional Medical History:

_____

_____

FOR WOMEN ONLY: **(PLEASE CHECK):**
□Pelvic Inflammatory disease □Endometriosis □Irregular Menstrual Cycle □Incontinence (urinary/fecal)
□Complicated pregnancies/deliveries

Please check box and sign below:
Consent □ I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature:_____ Date:_____