Name:______________________________________

Date:_______________________________________

Sport & Spine
Physical Therapy
"Improving Human Performance"

Please check the following conditions as they apply to you:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Problems

1. Is the injury you are being treated for due to a fall? Y / N

If yes, have you had 2 or more falls in the last year? Y / N

2. Surgical History? ☐ None

Operation	Month/Year

3. Current Medications: ☐ None

Drug	Dosage	Reason Taking

4. Are you currently pregnant? Y / N Or have you been in the last year? Y / N

5. Do you smoke? Y / N Do you drink alcohol? Y / N

6. Is this work related? Y / N Is this related to an auto accident? Y / N

7. Have you received physical therapy previously? Y / N For this same condition? Y / N

7. **Please describe your injury, location of pain and onset of problem:** ______________________________

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Please circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10

0 Being NO pain ***10 go to emergency room***