227 CENTRAL AVE | CHRISTIANSBURG
757 UNIVERSITY CITY BLVD. | BLACKSBURG
1480 S. MAIN STREET | BLACKSBURG
1014 CLEMENT ST | RADFORD
www.TOTALMOTIONPT.net

Name: _____ Physician's Name: _____

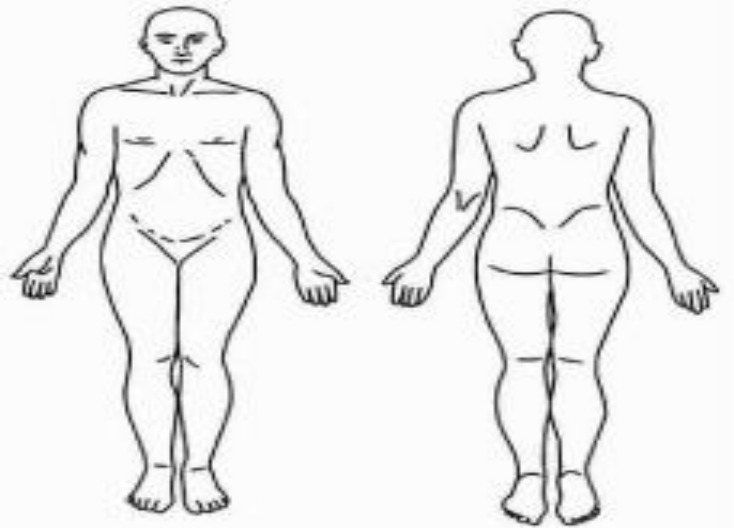
Height: _____ Weight: _____ **WOMEN ONLY**: Pregnant or possibly pregnant? YES NO

What is your primary complaint? _____

When was the date of your injury or surgery if applicable? _____

For the problem/ injury you are seeing us for today:

Mark your symptoms & location on body chart: X Pain ……. Numbness ------Tingling



Rate your **LOWEST** pain level in the **PAST 3 DAYS**
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Rate your **WORST** pain level in the **PAST 3 DAYS**
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Pain currently: Pain level **NOW**
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you had little interest or pleasure in doing things? YES NO

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Is this something you would like help with? YES NO
Do you smoke? _____packs/day YES NO

Please list current medications or give a copy to our front office staff: _____

_____

Are you currently taking blood thinning or anticoagulant medications? YES NO Latex sensitive? YES NO

Please list any surgeries or conditions you have been hospitalized for, including dates: _____

_____

_____

Existing or Relevant Previous Conditions—please circle any that apply:

Allergies
Anemia
Anxiety
Arthritis
Asthma
Autoimmune Disorder
Cancer
Cardiac Conditions
Cardiac Pacemaker
Chemical Dependency
Circulation Problems
Depression
Diabetes
Dizzy Spells
Dizzy Spells
Emphysema/Bronchitis
Fibromyalgia
Fractures
Gallbladder Problems
Headaches
Hearing Impairments
Hepatitis
High/Low Blood Pressure
High Cholesterol
HIV/AIDS
Incontinence
Kidney Problems
Metal Implants
MRSA
Multiple Sclerosis
Muscular Disease
Osteoporosis
Parkinson's
Rheumatoid Arthritis
Seizures
Speech Problems
Strokes
Thyroid Disease
Tuberculosis
Vision Problems

What is your goal for therapy at this time? _____

Patient Signature: _____ Date: _____