TOTAL MOTION PHYSICAL THERAPY

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: _____

CURRENT SYMPTOMS

Where are you currently having symptoms? _____

When & how did your symptoms/pain start? _____

My symptoms are currently (Circle One) Getting Better / Staying the Same / Getting Worse

Have you ever had this problem before? (Circle One) YES / NO

If so, how was the problem treated? _____

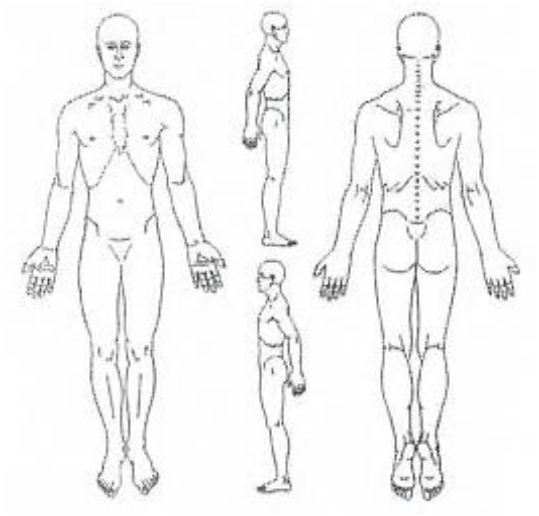
If so, how long did it take you to feel better? _____

Are you sleeping well at night? (Circle One) YES / NO

Have you had an X-ray, MRI or other imaging/study performed? (Circle One) YES / NO

BODY CHART

Please mark, on the chart below, the areas you feel symptoms and describe your pain: _____



On the scales below, please circle the number which best describes the severity of your pain

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

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PAST/CURRENT MEDICAL HISTORY (Please circle all that apply)

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

Please note any medical conditions not listed above that you have or have had in the past: _____

_____

Please list ALL CURRENT medications or attach a list: _____

_____

Are you currently taking blood thinning or anticoagulant medication? YES /NO Latex Sensitive? YES / NO

Please list past surgical history, including dates: _____

_____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING? (Circle all that apply)

Abnormal sensations Changes in Vision Constipation Easy Bruising Headaches

Light Headedness Night Sweats Unexpected weight loss/gain

What are your goals for physical therapy at this time? _____

Patient Signature: _____ Date: _____