CAMAS PHYSICAL THERAPY

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Date: _____ Age:_____

Name: _____ Work Status (circle): Normal/Light Duty/

Occupation: _____ Reduced Hours/Off

Height: _____ Weight: _____ Handedness (circle): Right Left

Referring Physician:_____ Diagnosis: _____

Date of Injury: _____ Date of Surgery: _____

What major complaint, symptom, or problem brings you here today?

Describe your symptoms specifically:

How did you symptoms begin, and how have they progressed?

Have you had this problem before?

Are your symptoms getting: □ Better □ Worse □ Staying the Same

Are your symptoms: □ Constant □ Intermittent

Place three circles below to indicate the intensity of your pain on **average**, at **best**, and at **worst**.

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

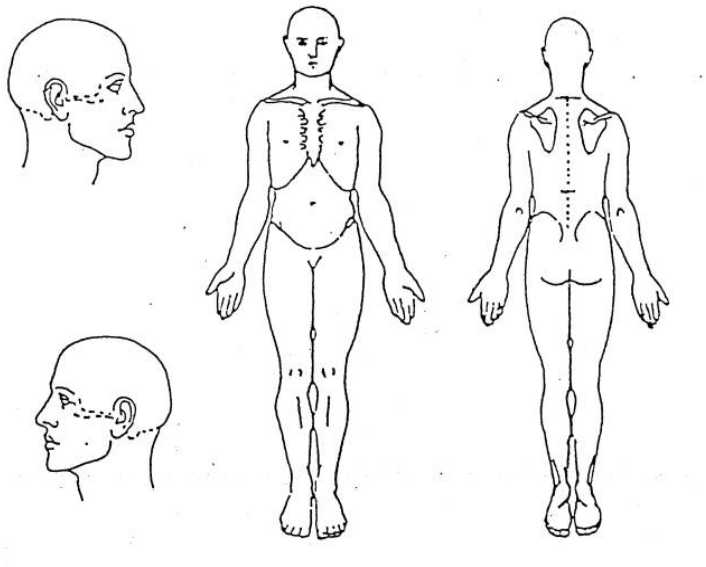
Do you have trouble falling asleep due to your symptoms? □ Yes □ No

Is your sleep restful? □ Yes □ No

How many times do you awaken during the night? _____

How long does it take you to go back to sleep?_____

Please indicate the location of your symptoms:



What increases your pain/symptoms? _____

What decreases your pain/symptoms? _____

What specific activities are you unable to do because of your symptoms? _____
_____

Please check the box of the activity that increases your pain or symptoms:

- □ Walking
- □ Standing
- □ Sitting
- □ Sit to stand
- □ Reaching
- □ Lifting/carrying
- □ Household chores
- □ Yard work
- □ Bathing/dressing
- □ Driving/riding in car
- □ Exercise
- □ Sports
- □ Sleeping/resting
- □ Playing with kids
- □ Climbing stairs
- □ Computer work
- □ Other:

Have you seen any of the following during the past 3 months?

- □ Physician
- □ Physical Therapist
- □ Massage Therapist
- □ Chiropractor
- □ Acupuncturist
- □ Other:

Have you had any of the following tests performed for this problem?

□ X-ray □ MRI □ CT scan □ Bone scan □ Blood Tests □ Other
Results:_____

Past Medical History
Do you have or have ever had any of the following?: (circle)

□ Anxiety	□ High Blood Pressure	□ Stroke	□ Fractures
□ Depression	□ Pacemaker	□ Thyroid problems	□ Sprains/strains
□ Diabetes	□ Heart Problems	□ Osteoarthritis	□ Fibromyalgia
□ Lung Problems	□ Dizziness/vertigo	□ Rheumatoid arthritis	□ Vision problems
□ Liver Problems	□ Recent falls	□ Headaches	□ Hearing problems
□ Cancer	□ Heart attack	□ Motor vehicle injury	□ Balance problems
□ Osteoporosis	□ Recent weight loss/gain	□ Neck/back problem	□

Use the following lines to explain/describe any of the above checked conditions, if needed.
_____
_____
_____

Have you had any past surgeries or hospitalizations? □ Yes □ No (List)
_____
_____
_____

Medications:
Please list all prescription and non-prescription medications:
_____
_____
_____

Allergies:
□ Medications □ Latex □ Adhesive tapes □ Other
List:_____

What are your goals for physical therapy?
_____
_____
_____