HUGHES
Your Bridge to Better Health
PHYSICAL THERAPY

Patient Name: _____ Date: _____

DO YOU HAVE A PACEMAKER? YES NO DEFIBRILLATOR? YES NO

******Please check all that apply:**

Do you have difficulty with: ( ) Sleep ( ) Self-care ( ) Daily living ( ) Reaching/pushing/pulling
( ) Lifting/carrying ( ) Sitting/standing ( ) Bending/squatting ( ) Mobility/ambulation

1. **WHEN** and **HOW** did your symptoms begin? (***DESCRIBE*** the onset of your symptoms):
   _____
   _____

2. Have you had any ***RECENT*** surgery or surgery within the last ***5 YEARS*** for this condition?
   ( ) YES ( ) NO Date of surgery: _____

3. Pain location: _____

4. Pain description (circle): Burning Dull/Achy Throbbing Shooting Numbness/Tingling Sharp

   OR Other: _____

5. On a scale of 0 to 10, please rate your pain for the following time frames:

   0 = NO PAIN 5 = MODERATE PAIN 10 = EXTREME PAIN

   At worst: 0 1 2 3 4 5 6 7 8 9 10
   Current: 0 1 2 3 4 5 6 7 8 9 10
   At Best: 0 1 2 3 4 5 6 7 8 9 10

6. Who have you seen for your symptoms?

   No One Medical Doctor Other Chiropractor Physical Therapist
   a. What treatment did you receive and when? _____

7. Have you had any RECENT imaging for your symptoms? ( ) Yes ( ) No
   If yes, when was it performed?

   X-rays date _____ CT scan date _____ MRI date _____ Other date _____

8. Have you had similar symptoms in the past? ( ) Yes ( ) No
   a. If yes, who did you see?
   This office Medical Doctor Chiropractor Physical Therapist

9. List all the surgical procedures you have had and times you have been hospitalized: _____
   _____

10. Please list any joint replacements and/or spinal procedures: _____
    _____

11. What is your Occupation? (If retired, what occupation are you retired from?) _____

Full-time Part-time Self-employed Other

12. What goal(s) do you hope to achieve by being treated with physical therapy? _____
_____

13. What type of regular exercise do you perform?

None Light Moderate Strenuous

14. **Do you have an allergy to: ( ) HEAT ( ) COLD ( ) LATEX ( ) NONE**

15. **Have you fallen in the past year? ( ) Yes ( ) No**

If yes, how many times? _____ How many falls resulted in injury? _____

16. For each of the conditions listed below, place a check in the **PAST** column if you have had the condition in the past. If you presently have a condition listed below, place a check in the **PRESENT** column.

	PAST	PRESENT		PAST	PRESENT
Cerebral Vascular Accident	□	□	Smoking/Tobacco Use	□	□
Traumatic Brain Injury	□	□	Drug/Alcohol Use	□	□
Cardiovascular disease	□	□	HIV/AIDS	□	□
Heart Attack	□	□	Hepatitis	□	□
Chest Pains	□	□	Asthma	□	□
Stroke	□	□	Allergies	□	□
Angina	□	□	Pregnancy	□	□
High Cholesterol	□	□	Anxiety	□	□
High Blood Pressure	□	□	Depression	□	□
Kidney Stones	□	□	Visual Disturbances	□	□
Kidney Disorders	□	□	Appetite Loss	□	□
Lupus	□	□	Immunosuppression	□	□
Huntington's	□	□	Shingles	□	□
Epilepsy	□	□	Obesity	□	□
Dizziness	□	□	Diabetes Type I	□	□
Parkinson's	□	□	Diabetes Type II	□	□
Dementia/Alzheimer's	□	□	Osteoarthritis	□	□
Fibromyalgia	□	□	Rheumatoid Arthritis	□	□
Liver/Gall Bladder	□	□	Current Infection	□	□
CANCER	□	□	TUMOR	□	□
If yes, what kind/location? _____			If yes, what kind/location? _____		
_____			_____		

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Please list prescriptions, over the counter medications, and supplements with dosages and route of intake:

If you already have a list of ***ALL of these factors, we would be happy to make a copy of it.

				Official use	
Medication	Dose	Frequency	Route of Intake	Changes	Date
			Oral/Spray/ Injection/Other		
			Oral/Spray/ Injection/Other		
			Oral/Spray/ Injection/Other		
			Oral/Spray/ Injection/Other		
			Oral/Spray/ Injection/Other		
			Oral/Spray/ Injection/Other		
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			Oral/Spray/ Injection/Other		
			Oral/Spray/ Injection/Other		