Release
PHYSICAL THERAPY

WELLNESS MADE BY HAND

Please describe your reason for seeking care:

Please describe your level of pain. "0"No pain to "10" Severe Pain

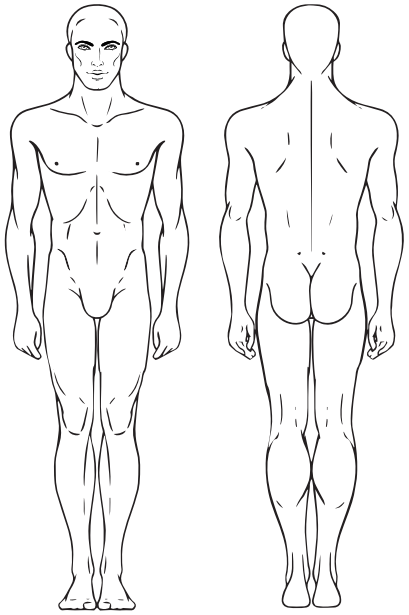
0 1 2 3 4 5 6 7 8 9 10

What aggravates your symptoms?

What relieves your symptoms?

What sleeping positions are the least comfortable?

What functional activities are the most difficult?



Please mark areas where pain exists.

Are you generally in good health? ☐ Yes ☐ No

Have you had any recent surgeries or hospitilizations? ☐ Yes ☐ No
If yes please specify

Are you currently taking any medications? *Please include all over-the-counter medications and vitamins.*

Have you ever taken a steroid? Example Cortisone, Prednisone. ☐ Yes ☐ No

Have you had any recent test such as blood work, X-ray or MRI? ☐ Yes ☐ No

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Mon–Thurs: 8a-7p Fri: 8a–4p Sat: By Appt.
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Name of primary care physician: _____

Are you currently seeing any other medical professionals? _____

Do you have, or have you ever been diagnosed as having, any of the following?

Yes	No	High Blood Pressure	Yes	No	Rheumatoid Arthritis
Yes	No	Heart Problems	Yes	No	Depression
Yes	No	Asthma	Yes	No	Hepatis
Yes	No	Emphysema	Yes	No	Tuberculosis
Yes	No	Chemical Dependency	Yes	No	Stroke
Yes	No	Thyroid Problems	Yes	No	Kidney Disease
Yes	No	Diabetes	Yes	No	Anemia
Yes	No	Multiple Sclerosis	Yes	No	Epilepsy

Yes No Cancer if yes, please describe

Yes No Other, If yes, please describe

Yes	No	Are you pregnant?
Yes	No	Do you experience and numbness in tingling in your genital area?
Yes	No	Have you recently gained or lost more than ten pounds?
Yes	No	Are you experiencing any bowel and bladder irregularities?
Yes	No	Do you experience weakness in your legs or balance problems?
Yes	No	Do you experience blurred vision, nausea, or difficulty breathing?
Yes	No	Have you had at least two or more falls in the past year?

I hereby certify that I have completely represented the state of my current health, such as it may be, to the best of my ability. I also understand that omitting information regarding my health may affect the course of treatment. I agree to allow Release Physical Therapy to examine me.

_____ _____
Signature Date

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