CLACKAMAS PHYSICAL THERAPY ASSOCIATES, INC.

CURRENT SYMPTOM INFORMATION

Name:_____

Place of Employment:_____

How Long? _____ Job Title: _____

Job Activities Required: _____

_____

Primary Care Physician: _____

Chiropractor: _____

Specialist/Other: _____

Please Describe Exercise Programs or Activities Performed Daily:

_____

_____

Have you been able to continue these? □ Yes □ No

If No, Why? _____

Please list any medications you are taking:

_____

_____

Please describe your **current** symptoms:

_____

_____

Did you have a recent injury/surgery? □ Yes □ No
Date: _____

How have your symptoms changed from when they first started?
□ Better □ Worse □ No Change

Please indicate how your injury originally occurred:
□ MVA □ Trauma □ Work injury
□ Fall □ Lifting □ Sports/Recreation
□ Unknown □ Other: _____

Please indicate descriptors that apply to your pain?
□ Aching □ Sharp □ Hot
□ Dull □ Pinching □ Shooting
□ Sore □ Throbbing □ Constant
□ Stabbing □ Burning □ Pins and Needles

Are you currently receiving any of the following treatment forthis condition?
□ Chiropractic □ Massage □ Physical Therapy □ Psychotherapy

Have you experienced any of the following, in the past year?
□ Numbness □ Fever/Sweats/Chills
□ General weakness □ Dizziness/Fainting
□ Fatigue □ Significant weight loss/Gain

What activities increase your symptoms?
□ Sitting □ Standing □ Walking
□ Lying down □ Squatting □ Coughing/Sneezing
□ Lifting □ Bending □ Up/Down stairs
□ Driving □ Stress □ Sports/Recreation

What activities decrease your symptoms?
□ Sitting □ Standing □ Walking
□ Lying down □ Heat □ Ice
□ Stretching □ Rest □ Other

Have you had previous episodes in the past? □ Yes □ No
If yes, how many? □ 1-3 □ 4-10 □ 11 or more

Testing: (Check all that apply)
□ MRI Scan □ X-Ray □ CT Scan
□ Bone Scan □ Other

Please rate your pain level in the last 7 days: (Circle)

At best { 0 1 2 3 4 5 6 7 8 9 10 }
No pain Intolerable

At worst { 0 1 2 3 4 5 6 7 8 9 10 }
No pain Intolerable

Day Pattern

In the morning my symptoms are:
□ Better □ Worse □ No Change

In the evening my symptoms are:
□ Better □ Worse □ No Change

Sleeping

□ I sleep through the night. □ I awaken frequently because of my current symptoms.

Do you have increased pain upon getting out of bed in the morning?
□ Yes □ No

What are your goals for physical therapy?

_____

_____