Alpine Physical Therapy & Spine Care Patient Name:

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

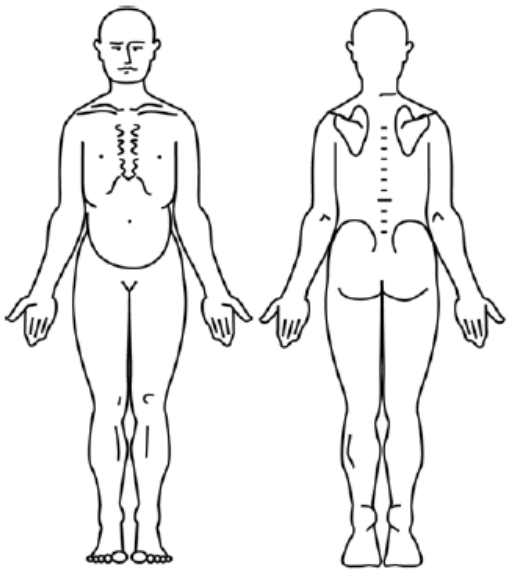
Is this condition getting progressively worse? ☐YES ☐NO ☐UNKNOWN

Are you having trouble sleeping? ☐YES ☐NO

Normal hours of sleep: _____ hours Current hours of sleep: _____ hours

Have you had any prior treatment for your current condition? (check all that apply)
☐Hospitalization ☐Bracing/Taping/Casting ☐Physical Therapy ☐Surgery
☐TENS/Stimulation Unit ☐Injections ☐Chiropractic ☐Acupuncture
☐Other _____

Before the onset of my current symptoms (or prior to injury), I was:
☐Independent in all activities ☐Independent with self-care only
☐Needing assistance with some activities ☐Needing assistance with most activities
☐Dependent for all care



Mark an X on the picture where you continue to have pain, numbness or tingling.

Please mark your level of pain with an X along the following lines:

What is your level of pain at rest?
No Pain Worst Pain Imaginable

What is your level of pain with activity?
No Pain Worst Pain Imaginable

HEALTH HISTORY

Medical conditions you currently have or have had in the past:

☐Heart Problems
☐Fainting or Dizziness
☐Shortness of Breath
☐Calf pain with exercise
☐Severe Headaches
☐Recent accident
☐Head Trauma/concussion
☐Muscular weakness
☐Cancer: _____
☐Joint dislocation
☐Broken bones
☐Difficulty sleeping
☐High blood pressure
☐Epilepsy/Seizures/convulsions
☐Constant pain unrelieved with rest
☐Mouth numbness
☐Kidney Disease
☐Liver Disease
☐Weakness or fatigue
☐Hernia
☐Blurred vision
☐Circulatory problems
☐Jaw problems
☐Any infectious disease *(TB, Aids, Hepatitis)*
☐Difficulty swallowing
☐A wound that does not heal
☐Unusual skin condition
☐Lung disease/problems
☐Arthritis
☐Swollen and painful joints
☐Irregular Heartbeat
☐Stomach pain or Ulcer
☐Back or neck injuries
☐Pain with cough or sneeze
☐Stroke
☐Muscular pain with activity
☐Frequent falls
☐Chest pain or pressure at rest
☐Nervous or emotional problems
☐Pacemaker/implanted stimulator
☐Bowel/bladder problems
☐Diabetes: type _____
☐Balance problems
☐Swollen ankles or legs
☐Tremors
☐Night pain while sleeping
☐Unexplained weight loss
☐Pregnancy

HABITS

Smoking Packs/day _____
Alcohol Drinks/week _____
Coffee/Caffeine Drinks Cups/day _____
High Stress Level Reason _____
_____

ALLERGIES

_____
_____
_____
_____

PRIOR SURGERIES

_____
_____
_____
_____

MEDICATIONS

_____
_____
_____
_____
_____

EXERCISE

☐None ☐Moderate ☐Daily ☐Heavy
Type _____
_____
Times per week _____

WORK ACTIVITY

☐Employed ☐Employed with restrictions
☐On medical leave ☐Not employed ☐Retired
Type of Work _____
☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor