

Diagnostic Tests and Measures – Within the past year, have you had any of the following (Check all that apply):

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> No Diagnostic Testing | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> EMG/ Nerve conduction | <input type="checkbox"/> Stool Test |
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> MRI | <input type="checkbox"/> Urine Test |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Pap Smear | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Blood Test | <input type="checkbox"/> EEG | <input type="checkbox"/> Pulmonary Function Test | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> EKG | <input type="checkbox"/> Spinal Tap | <input type="checkbox"/> _____ |

Current Condition(s)/Chief Complaints:

- Nature of Onset/Injury**
- | | | |
|---|--|--|
| <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Fall | <input type="checkbox"/> Unknown Onset |
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Traumatic Event | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gradual Onset | <input type="checkbox"/> Ongoing/Chronic Condition | |

Date of Onset: _____

Briefly Describe What Happened? _____

Chief Complaints or Problems? _____

Overall, How Would You Describe the Intensity of your Symptoms? Slight Minimal Moderate Severe Emergency

Overall, How Frequent Are Your Symptoms? Intermittent (off & on) Occasionally (sometimes) Constant (all the time)

Have you ever had this problem(s) before? Yes No

What did you do for the problem(s)? _____

Did the problem get better? Yes No **How long did the problem last?** _____

What Makes Your Symptoms Worse? _____

What Makes Your Symptoms Better? _____

What is Your Goal For Physical Therapy? _____

Are You Seeing Anyone Else For Your Problem? Yes No
If Yes, Please Check all that Apply.

- | | | | | |
|--|---------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Family Doctor | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Rheumatologist | <input type="checkbox"/> _____ |

Tests & Measures (office use only):
