LAKE COUNTRY PHYSICAL THERAPY & SPORTCARE, P.C.

Name _____ Date _____ Account # _____

What is your current problem (why you are here)? :_____

How did your problem begin? ☐Injury ☐unknown cause ☐repetitive stress ☐Other: _____

When did your condition start? (1, 3, 6 months ago) or on this date: _____

Did you have surgery? ☐No ☐Yes if yes, when: _____ type of surgery _____

What activities or positionsworsen your symptoms? _____

What have you found thathelps reduce your symptoms? _____

Have you been treated for the same problem in the past? ☐Yes ☐No Type of Treatment: _____

Is your sleep interrupted by pain? ☐Yes ☐No How many uninterrupted hours of sleep do you get a night? _____

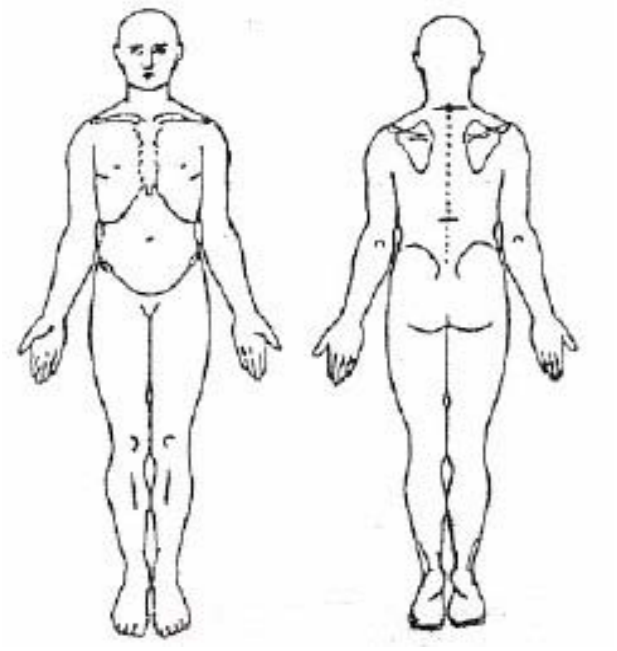
Are you currently working? ☐Yes ☐No Date you last worked: _____Type of work: _____

What types of hobbies or recreational activities do you participate in now? _____

How best do you learn? ☐watching/listening ☐performing ☐reading ☐other: _____

What would you like to accomplish in physical therapy (your goal)? _____

Please draw where you have pain or symptoms below:



What is your pain level at rest? Circle one
(no pain = 0) 0 1 2 3 4 5 6 7 8 9 10 (maximal pain = 10)
What is your pain level with movement?
0 1 2 3 4 5 6 7 8 9 10
Your pain or symptoms are:
☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Shooting Burning ☐Tingling
☐Constant ☐Frequent ☐Occasional ☐Rarely

List Medications: Reason taking:

List Recent Medical Test/date (x-rays, MRI, EMG):

List Previous Surgeries/Hospitalizations:

W eight: _____ Height: _____