

MSI PHYSICAL THERAPY

Name: _____ Age: _____ Date of Birth _____ Height _____ Weight _____

Cell Phone Number _____

Email Address: _____ Would you like to receive our newsletters? Yes No
(For MSI use only)

Is this related to an accident? Auto Work Other _____ Date of Incident: _____

Occupation: _____ Are you working: Yes No - Date Last Worked _____

Main complaints in order of importance:

How & when did this problem begin?

Surgery/Hospitalization:

Type	Year	Complications
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Current Medications:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Treatment to date: Chiropractic Injections Physical therapy Other _____

Rate your pain from 1 to 10 _____ (1 mild – 10 severe) Baseline _____ Worst _____

Medical History:

Numbness/tingling Headache
 Bladder dysfunction Hepatitis type _____
 Bowel dysfunction HIV/AIDS
 Arthritis Depression
 Menopause (female) Lungs
 Other _____

Other Medical Complaints:

Vision Ears/Nose/Throat
 Blackouts/Fainting Bleeding/Clotting
 Balance/Dizziness Digestion
 Hypertension Psychiatric History
 Headaches Seizures

Please check & explain any of the above that apply to you _____

Activities that increase your pain: Moving Lifting Carrying Reaching Sitting Standing Walking
 Bending Driving Sleeping Stairs Running Squatting Other _____

Please check if you:

Exercise regularly Describe _____ Are you on a special diet – describe _____
 Smoke PPD _____ Quit – When _____ Alcohol – How often _____

Recreational interests: _____

What are your goals in physical therapy?: _____

What can you not do now due to your symptoms?: _____

I certify that all of the above is accurate, complete, and without fabrication or suppression.

Signature _____ Reviewed by _____