What body part are we seeing you for today?

❑ Left ❑ Right

❑ Back ❑ Neck ❑ Shoulder ❑ Elbow ❑ Wrist ❑ Hand

❑ Hip ❑ Knee ❑ Ankle/Foot ❑ Vestibular ❑ Balance ❑ Other

If other, please describe:_____

What was the date of your injury?_____

If you had surgery, describe:_____

Date:_____

How would you rate your current pain on a 1 to 10 scale?_____

Prior to your injury, were you independent with your activities of daily living and walking?

_____

Are you currently having home PT/OT services? YES / NO

Past Medical History:

❑ No Significant PMH
❑ Alzheimer's
❑ Cauda Equina Syndrome
❑ Cerebral Vascular Accident (CVA)
❑ Current Infection
❑ Diabetes Type 1
❑ Diabetes Type 2
❑ Fibromyalgia
❑ Fracture or Suspected Fracture
❑ High Blood Pressure
❑ History of Cancer
❑ Huntington's
❑ Immunosuppression
❑ Lupus
❑ Muscular Dystrophy
❑ Obesity
❑ Osteoarthritis
❑ Parkinson's
❑ Rheumatoid Arthritis
❑ Traumatic Brain Injury
❑ Other: _____

Are you currently taking any medications?_____

_____

_____

_____

What are your goals for therapy?_____

MOVEMENT
PHYSICAL & OCCUPATIONAL THERAPY