FYZICAL®
Therapy & Balance Centers

For Office Use Only: Initial Evaluation
Date: ____/____/_____
Time: _____
Therapist: _____

PATIENT MEDICAL HISTORY

Date: _____/_____/_____ Date of Birth: ____/____/____ **Age:** _____ **Height**_____ **Weight**_____

Name: _____ Referring Physician: _____

Social Security No: _____-____-_____

Local Address: _____ Out of State Address: _____

City _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: (_____) ____ - _____

Email: _____ Alt Phone:(_____) _____-_____

Emergency Contact: _____ Phone: (____) _____-_____

How would you like to receive automated REMINDERS for future appointments? Email ____ Phone _____ Text _____

How did you hear about us? (check all that apply) Doctor: _____ Walk-in/Self: _____ Friend: _____ Other: _____

What is your main complaint: _____ What body part? _____

What are your goals for therapy? _____

Date of injury/onset of this condition? _____ Date of Surgery _____

Have you recently had Home Health? If yes, company name _____ **Discharge date:** _____

Are you currently receiving Chiropractic Care? Yes_____ No _____

Have you ever had any of the following medical or rehab services for this injury? (Please check what applies)
Chiropractor ____ EMG/NCV ____ Massage Therapy ____ Myelogram ____ Occupational Therapy ____
Physical Therapy ____ Emergency Room Care ____ CT Scan ____ General Practitioner ____ MRI ____
Neurologist ____ X-Ray ____ Orthopedist ____ Podiatrist ____ Other _____

Do you have or ever had any of the following? (Please check what applies)

____ Asthma
____ Emphysema
____ Shortness of Breath
____ Chest Pain
____ Pacemaker / Defibrillator
____ High Blood Pressure
____ Heart Attack or Surgery
____ Stroke / TIA
____ Heart Problems
____ Blood Clot / Emboli
____ Thyroid Trouble / Goiter
____ Anemia
____ Infectious Disease
____ Cancer or Chemo / Radiation
____ Uncontrolled Leakage of Urine
____ Loss of Bowel Control
____ Osteoarthritis
____ Osteoporosis
____ Epilepsy / Seizures
____ Severe / Frequent Headaches
____ Hearing Problems
____ Vision Problems
____ Numbness or Tingling
____ Dizziness
____ Fainting
____ Weakness
____ Lung Disease
____ Varicose Veins
____ Joint Replacements
____ Any Pins / Metal Implants
____ Neck Injury / Surgery
____ Back Injury / Surgery
____ Currently Pregnant
____ Tobacco Use
____ Alcohol Use
____ Psychological Problems
____ Rheumatoid Arthritis
____ Diabetes

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1. Dominant Hand: **L / R**. Trouble side: **L / Center / R**

Symptoms started **gradually** or **abruptly**? _____

2. What impairment brings you to therapy (be specific)? _____

3. How did injury occur **or** symptoms begin? _____

4. Have symptoms changed since onset? **Y or N** Any previous similar symptoms? **Y** or **N**

5. Any previous treatment? **Y or N** Helpful? **Y or N** Chiropractor: **Y or N**

****Pain: 0 = No Pain 10 = Excruciating Pain which requires emergency care in the E.R.****

6. Today's Pain: 0 1 2 3 4 5 6 7 8 9 10.

7. Pain at Worst: 0 1 2 3 4 5 6 7 8 9 10. At Best: 0 1 2 3 4 5 6 7 8 9 10

8. Superficial/Deep Intermittent/Constant Type of pain: Sharp/Dull/Achy/etc. _____

9. Is there a time of the day your pain is worse? _____ Better? _____

10. What positions/activities **Increase** your symptoms **(Circle all that apply)**: Lying Sitting Sit-Stand Stand Walking Running Lifting Bending Up-Stairs Down-Stairs Other: _____

11. What positions/activities **Decrease** your symptoms **(Circle all that apply)**: Lying Sitting Sit-Stand Stand Walking Running Lifting Bending Ice Heat Massage Meds Other: _____

12. If you have back/neck pain: does coughing/sneezing worsen symptoms? **Y** or **N**

13. If you have back/neck pain: do symptoms/pain radiate into arms/legs? **Y or N**

- If yes, describe radiating pain: _____

14. Experienced any **unexpected** weight loss recently? **Y** or N. Pain worse after eating? **Y** or N

15. Recent results of: X-ray (if any) _____

MRI: _____

Other Treatment: _____

16. Previous Major Surgeries: _____

17. Any Major illnesses/conditions? _____

18. Current limitations affecting daily activities: _____

19. List Medications currently taking (see attached List): _____

20. Have you fallen in the past 12 months? **Y** or **N** Did you incur an injury? **Y** or **N**

What do YOU WANT TO achieve from having therapy? Check all that apply:

___ Improve home activities ___ Improve mobility/walking activities ___ Improve self care activities

___ Return to work ___ Decrease or eliminate pain/discomfort ___ Improve leisure/sports activities

To the best of my knowledge, the above information is complete and factual.

_____ _____

Patient Signature Date