BodyRenovation
ADVANCED TECHNIQUES IN PHYSICAL THERAPY

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PATIENT INJURY REPORT

Patient Name_____ Date of birth _____ Today's date _____

1. Reason for visit: _____ When did this occur? _____

2. How did this occur? _____

3. What are your symptoms of concern? _____

4. Have you had similar issues in the past? _____

5. What makes your pain worse? Nothing Standing Sitting Lying Down Movement Inactivity

6. What makes your pain better? Nothing Standing Sitting Lying Down Movement Inactivity

7. Are your symptoms worse: Morning Afternoon Night Increase throughout day All day

8. How often do you experience symptoms:

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

9. How much has this affected your normal work (including at home)? None A little Moderately A lot Extremely

10. How much has this affected your social activities? None A little Moderately A lot Extremely

11. Have you had others look at your symptoms? Primary Care Specialist Physical Therapist Chiropractor

X-ray date: _____ MRI date: _____ CT Scan date: _____ Other: _____

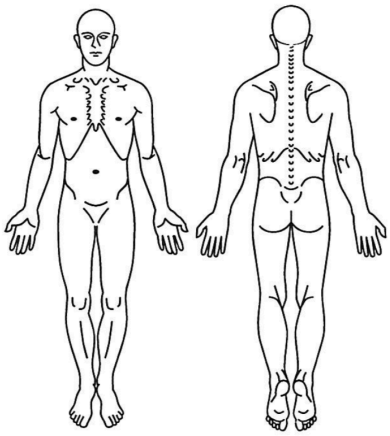
Surger(ies) and date(s): _____

12. What are your goals for physical therapy? _____

_____

PAIN DIAGRAM

Please use the following diagram below to indicate where you feel your symptoms currently.
Use the key below to indicate the different types of symptoms.



KEY
Pins & Needles = 00000
Stabbing = /////
Burning = XXXXX
Deep Ache = zzzzz

Other notes:

Please rate your pain using the following scale:

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst Imaginable pain)

Today: _____/10 At Best: _____/10 At Worst: _____/10

— TURN OVER —

PATIENT MEDICAL HISTORY

Patient Name_____ Date of birth _____ Today's date _____

Height _____ feet _____inches Weight _____ Staff initials _____

Overall, your health is: Excellent Very Good Good Fair Poor

MEDICATION LIST

Medication	Dosage	Frequency	Route of Admin.

What is your current work status? ____ Full time ____ Part time ____Self Employed

____ Unemployed ____ Retired ____Other _____

What are your work activities (if applicable): _____

What are your leisure activities? _____

Current conditions (please check all that apply):

____ Dizziness/Falls ____ Fever/Chills ____ Pain at night _____

____ Fainting ____ Nausea/Vomiting ____ Shortness of breath

____ Fatigue ____ Headaches ____ Unexplained weight change

Do you use tobacco? Yes No Do you drink alcohol? Yes No

Past history (Please check all that apply):

____ No significant history ____ Eating Disorder ____ Multiple Sclerosis

____ Alzheimer's ____ Emphysema/Bronchitis (COPD) ____ Osteoporosis

____Anemia ____ Epilepsy ____Pacemaker/Other Implant

____ Anxiety ____ Gout ____ Psychological Disorder

____ Asthma ____ Heart Attack ____ Rheumatoid Arthritis

____ Blood Clots ____ Heart Disease ____ Scoliosis

____ Bowel/Bladder Issues ____ Hepatitis ____ Sexual Dysfunction

____ Cancer ____ Hernia ____ Sleep Apnea

____ Circulatory Disease ____ High Blood Pressure ____ Stroke

____ Depression/Anxiety ____ High Cholesterol ____ Substance Abuse

____ Diabetes ____ Kidney Stones/Disease ____ Thyroid Issues

____ DVT (Blood Clot) ____ Latex Allergy ____ Tuberculosis