biomechanix
PHYSICAL THERAPY

Patient Name: **Date:**

Are you currently taking any medications? Yes___ No___ Please List: _____
Are you currently receiving home health care? Yes___ No___

Condition	Yes	No	Date	Condition	Yes	No	Date
Asthma	___	___	_____	Fracture/Broken Bones	___	___	_____
Diabetes	___	___	_____	Neuromuscular	___	___	_____
High Blood Pressure	___	___	_____	Dizziness/Blackouts	___	___	_____
Heart Problems	___	___	_____	Headaches/Migraine	___	___	_____
Lung Problems	___	___	_____	Blood Clots/ Vascular	___	___	_____
Cancer	___	___	_____	Bladder/Bowel Disorder	___	___	_____
Seizures	___	___	_____	Pregnancies # _____	Dates: _____		
Arthritis	___	___	_____	Other: _____			
Stroke/CVA	___	___	_____				

Surgical	Yes	No	Date	Please Describe
Orthopedic Surgery	___	___	_____	_____
Joint Replacements	___	___	_____	_____
Spinal Surgery	___	___	_____	_____
Heart Surgery	___	___	_____	_____
Fracture Reductions	___	___	_____	_____
Joint Manipulations	___	___	_____	_____
Other Surgeries	___	___	_____	_____

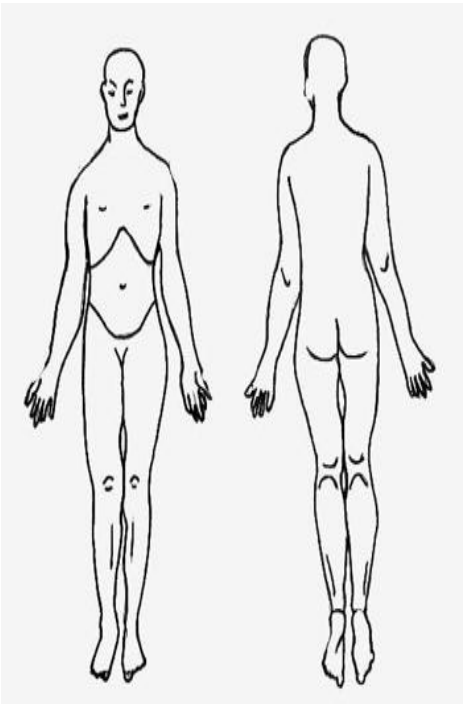
Current Limitations/Restrictions _____

Diagnostics	Yes	No	Date	Results
X-Rays	___	___	_____	_____
CT Scans	___	___	_____	_____
MRI	___	___	_____	_____
EMG Nerve Studies	___	___	_____	_____
Injections	___	___	_____	_____

Pain/Symptoms

1. Please rate your current pain level by marking a number on the scale:
   0 _____ 10
   (No Pain) (ER Visit)

2. On the **BODY DIAGRAM►** please describe your symptoms using the Following symbols: (X) Sharp (=) Numb/Tingling (#) Ache (B) Burning



Patient/Guardian Signature: _____