Berube PHYSICAL THERAPY

Today's Date:	**Primary Physician/Practitioner:**
Date of Injury/Surgery:	**Surgeon:**

PATIENT INFORMATION

Patient's last name:	**First:**	**MI:**	

Birth date:	**Age:**	**Gender:**	**Reason you chose our clinic:**	**Occupation:**

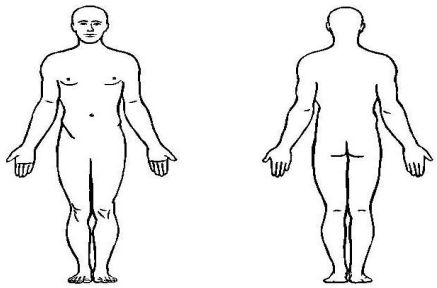
Please tell us about your current issue that you are seeking therapy for:

What are you symptoms doing: (please circle) Getting Better Getting Worse No Change In what ways?: _____ _____ _____	**Have you ever had: (circle all that apply)** Injections Previous PT Massage Chiropractic Pain Medication Give Details:_____ _____ _____	**Have you had Surgery?** No Yes Date of Surgery: _____ What was done?_____ _____ _____
Have you had any falls in the past 12 months? Yes No Please Explain: _____	**Have you ever been disabled?** Yes No Please Explain: _____	**What are your hobbies/Interests?**

Other family members seen here:

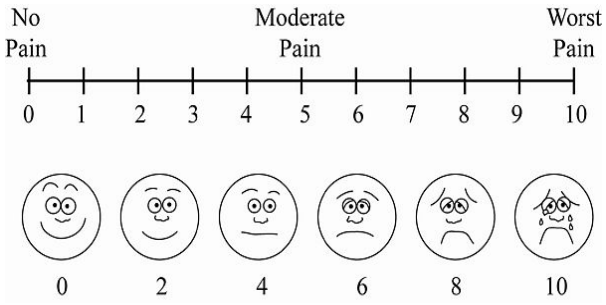
BODY MAP

PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN OR SYMPTOMS WITH AN "X"



RATE YOUR PAIN ON A SCALE OF 1 TO 10

AT BEST: /10 CURRENT: /10 AT WORST: /10



Describe your Symptoms (circle all that apply) Constant Occasional Achy Deep Superficial Sharp Burning Shooting Numbness Tingling Other: _____	**Is your pain worse at times of the day?** Yes No **When?** Morning Night	**Can you Sleep?** Yes No

FUNCTIONAL RESTRICTIONS

What activities are you having difficulty completing at this time? (circle all that apply)

Driving Work Tasks
Walking Dressing/Grooming
Running Sleeping
Housework Carrying/Lifting Objects
Standing Up/Down Stairs
Other _____

What makes your pain worse? (circle all that apply)

Sitting Housework
Standing Work Tasks
Walking Lifting
Lying Down Bending Over
Reaching Getting Dressed
Exercise Squatting
Other _____

What makes your pain better?

Ice Pain Medication
Rest Stretching
Elevation Walking
Ibuprofen Sleeping
Other _____

What household activities are you having difficulty performing? (circle)

Cooking Laundry
Cleaning Vacuuming
Yardwork Grocery Shopping
Other _____

PREVIOUS MEDICAL HISTORY

Please circle all that apply:

Allergies
Asthma/COPD
Cancer – Type _____
Chronic Pain
Depression/Anxiety
Diabetes I or II
Fibromyalgia
Fracture
Gallbladder Issues
High Blood Pressure
Hypothyroid
Hypoglycemia
History of Stroke or TIA
History of Heart Attack or Disease
Kidney Issues
Osteoporosis
Osteoarthritis
Pacemaker
Pregnancy
Radicular Pain
Rheumatoid Arthritis
Seizures/Epilepsy
Surgeries (please list) : _____
_____
_____
_____

What Medications are you taking?

Name	**Dose**	**How Often?**

What are your goals for Physical Therapy? _____
_____
_____
_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Berube Physical Therapy, Inc. or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ **Date** _____