THE RECOVERY ROOM
PHYSICAL THERAPY AND ATHLETIC CENTER
MOVE. PERFORM. EXCEL.

Name _____ *DOB* _____

*Primary physician*_____ *Phone* _____

Please check if you have or have had the following conditions:

*Asthma*_____	*Joint Replacement*_____	*Cancer* _____
*Emphysema*_____	*Vision difficulty*_____	*Arthritis* _____
*Pacemaker/ Defribillator*_____	*Hearing difficulty* _____	*Osteoporosis*_____
*Heart Surgery*_____	*Dizziness*_____	*Latex or other allergy* _____
Heart attack _____	*Fainting*_____	*High Blood Pressure* _____
*Stroke/ TIA*_____	*Epilepsy or seizure*_____	*Are you pregnant?* _____
*Diabetes*_____	*Infectious diseases* _____	*Do you smoke?* _____

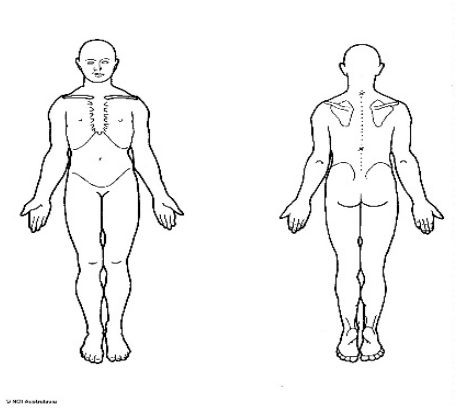
Please briefly describe why you are here for today's visit _____

_____

Please mark your pain intensity on the numeric pain scale

0 1 2 3 4 5 6 7 8 9 10

Please mark the location of your symptoms on the diagram



Describe your symptoms by checking any that apply

Sharp _____ *Burning* _____ *Tingling*_____

*Numbness*_____ *Dull*_____ *Ache*_____

Medicare Only:

*Height*_____ *ft, in Weight*_____ *lbs*

*Have you had any falls within the last year?*_____

*If yes, did you sustain an injury?*_____

**Please attach a list of all current medications*

Additional comments _____

_____

Signature (Guardian) _____ *Date* _____ *PT Initials* _____