

PALMER PHYSICAL THERAPY for WOMEN
10333 E. 21st Street N. Suite 406 Wichita, KS 67206 316.630.9944

SURVIVE & THRIVE

Date: ____/____/____

Name: _____ Age: _____ Height: _____ Weight: _____

Referring Physician: _____ Next appt. with physician: _____

Oncologist: _____ Surgeon: _____ Radiologist: _____ Plastic: _____

Occupation/Type of Work: _____ Hours per week: _____

How did you find out about us? TV Radio Billboard Website Doctor Other _____

Medical History:

- Recent Unexplained Weight Loss Current treatment to suppress immune system Hysterectomy Depression
- Neck/Back Surgery Heart Disease Pacemaker High Blood Pressure Diabetes Osteoporosis/Osteopenia
- Lung/Breathing Problems Arthritis Pelvic Pain Urinary Incontinence Seizures Allergies Metal Implants
- Stroke/CVA Kidney Problems Fractures Recent Accident (If yes, explain _____)
- Intolerance to Heat or Cold Skin Problems Other _____

Have you used a tobacco product in the past year? Yes No

Do you have a fear of falling? Yes No Have you fallen in the past year? Yes No (If yes, how many falls? _____)

Were you injured in a fall in the past year? Yes No (If yes, explain _____)

Has your physician limited your activity? Yes No (If yes, explain _____)

Current Medication List: Please bring a copy with you to your appointment

When did the problem(s) begin? (Date of Injury/onset) _____

Please rate your pain level with these activities from 0 to 10

0=no pain, 1=very mild, 2=discomforting, 3=tolerable, 4=distressing,
5=very distressing, 6=intense, 7=very intense, 8=utterly horrible,
9=excruciating, 10= will go unconscious shortly

_____ at worst _____ at best _____ on average _____ current

Does your pain radiate into your arm or leg? Yes No

If so, how far down does the pain travel? _____

Do you have numbness or tingling? Yes No

If so, where? _____

What makes your pain worse? _____

What decreases your pain? _____

Have you had these symptoms before? Yes No

Have you had prior treatment for this problem? Yes No If Yes, explain: _____

Do you feel fatigued? Yes No Mild Mod. Severe

Do you have tightness? Yes No Where? _____

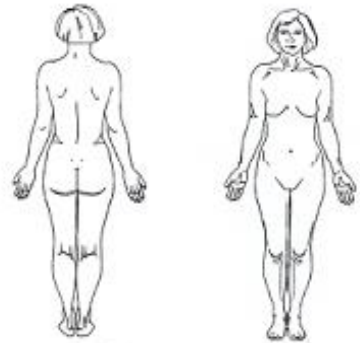
Do you have painful intercourse or have pain with the use of a tampon? _____

Do you participate in sports, exercise programs, or activities? _____

Briefly describe any additional symptoms you are having: _____

Additional Comments: _____

Please Mark Location Of Your Pain



KEY: Numbness =====

Pins/Needles 000000

Burning Pain XXXX

Stabbing Pain /////