PALMER PHYSICAL THERAPY for WOMEN

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SURVIVE & THRIVE

Date: _____/_____ /_____

Name: _____ Age: _____ Height: _____ Weight: _____ (Confirmed: _____)

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
☐ 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 _____
Do you smoke? ☐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 _____)

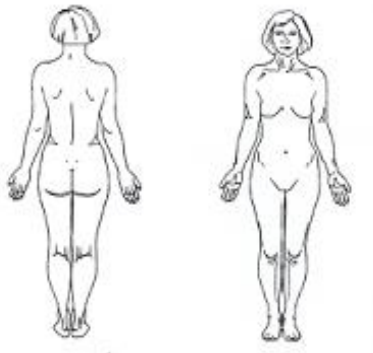
Current Medication List: Please bring a copy with you to your appointment (PT Received/Reviewed ☐Yes☐ No)

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

Please Mark Location Of Your Pain



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:

_____

KEY: Numbness =====
Pins/Needles 000000
Burning Pain XXXX
Stabbing Pain /////

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: _____

_____

_____