<table>
<thead>
<tr>
<th>Have you experienced any change in bowel/bladder habits?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Please list any other surgeries/injuries that have occurred in the last 5 years:

| Please check any over the counter medications you’ve taken in the past week: |
|---------------------------------|---------------------------------|
| Aspirin                         | Tylenol                         |
| Advil/Motrin/Ibuprofen          | Laxatives                       |
| Decongestants                  | Antacids                        |
| Antihistamines                 | Vitamins                        |

Please list current PRESCRIPTION medications:

<table>
<thead>
<tr>
<th>Do you have any of the following symptoms?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss/gain</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Numbness/Tingling</td>
</tr>
</tbody>
</table>

Please indicate medical tests completed for the current problem:

<table>
<thead>
<tr>
<th>Have you previously received physical therapy for the current problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

Explain:________________________________________________________________

Please turn over and complete the back page..............
On the following pain scale, please rate the pain you are experiencing:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO Pain</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please check any adaptive device(s) you may use:
- _____ Cane
- _____ Crutches
- _____ Brace
- _____ Sling
- _____ Shoe lift
- _____ Splint
- _____ Walker
- _____ Wheelchair
- _____ Other: ___________________________________

Please shade affected area(s):

Please describe the pain you are experiencing:

Is your injury work related? Yes No
Have you missed work due to your injury? Yes No
Are you currently working? Yes No
Are you a student? Yes No
Do you live... Alone Family/Friends

Please check the following activities that you CANNOT perform, or have pain/discomfort while performing:
- _____ Walking
- _____ Cooking
- _____ Stairs
- _____ Eating
- _____ Sitting
- _____ Yard Work
- _____ Sleeping
- _____ Snow Removal
- _____ In/Out of Bed
- _____ Dressing
- _____ In/Out of Vehicle
- _____ Using the Bathroom
- _____ Driving
- _____ Showering
- _____ Garbage Disposal
- _____ Sitting in Class
- _____ Combing Hair
- _____ Studying
- _____ Laundry
- _____ Writing
- _____ Cleaning
- _____ Other: __________

What are your goals for physical therapy?

Evaluation notes:

Patient Signature (Parent/Guardian) Date

Reviewed by Date