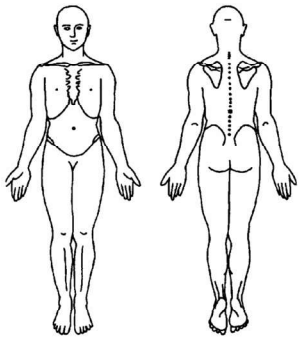
Please take your time to accurately complete. Detail will help your therapist with the evaluation.

I. Pain

1. Please mark picture where you have pain or other symptoms →



2. Please describe your pain: (CHECK THAT APPLY)
   - □ Localized □ Radiating
   - □ Constant □ Frequent □ Intermittent
   - □ Sharp □ Dull /Achy □ Burning □ Electrical □ Throbbing
   - □ Deep □ Superficial
   - □ Other:_____

3. Rate your pain perception on the following scale: 0 = No Pain

(Lowest)	1	2	3	4	5	6	7	8	9	10	(Highest)
	□	□	□	□	□	□	□	□	□	□	

II. Symptoms

1. Date of injury/onset of symptoms _____
2. Cause of injury: ❑ Car Accident ❑ Work-related ❑ Sport ❑ None ❑ Other: _____
3. Symptoms at onset: _____
   _____
4. Symptoms now: ❑ Same ❑ Better ❑ Worse _____
   _____

Worse when: (circle all that apply) Bending, Sitting/Rising, Standing, Walking, Lying, Kneeling, Overhead Activities, Dressing, Other:

_____

Better when: (circle all that apply) Bending, Sitting/Rising, Standing, Walking, Lying, Kneeling, Overhead Activities, Dressing, Other:

_____

Previous treatment: ❑ Physical Therapy ❑ Chiropractic ❑ Massage ❑ Acupuncture
❑ Other: _____

Result of Treatment: _____

Current Functional status (%)

100% ---- 90% ---- 80% ---- 70% ----- 60% ---- 50% ----- 40% ----- 30% ----- 20% ----- 10% -----0%

_____ _____

Patient Signature Date

St.Augustine Office: 105, Southpark Blvd., Suite B 201, St.Augustine, FL 32086 Ph: 904-824-1636, F: 904-824-7488
Jacksonville Office: 644 Cesery Blvd, Suite 200, Jacksonville, FL 32211 Ph: 904-903-2755, F: 904-903-2756
Orange Park Office: 904 Park Avenue, Suite 2, Orange Park, FL 32073 Ph: 904-420-3915, F: 904-420-3916
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Medical Treatment Form

Past/Current Medical History

❑ No significant past medical history

❑ Arrhythmia
❑ Asthma
❑ Cancer
❑ Congestive Heart Failure
❑ COPD
❑ Coronary Artery Disease
❑ Depression
❑ Weaken Immune System
❑ Diabetes
❑ Fractures
❑ Heart Attack
❑ Dates: _____
❑ History of falls
❑ Hypertension
❑ MS
❑ Others: _____
❑ Mitral Valve Prolapse
❑ Osteoporosis
❑ Pacemaker
❑ Currently Pregnant
❑ PVD (Vascular Disease)
❑ Rheumatoid Arthritis
❑ Stroke

History of: ❑ Smoking ❑ Alcohol ❑ Substance Abuse ❑ Other: _____
Family History of Current Condition: ❑ No ❑ Yes, Explain: _____
Other Significant Family History: ❑ None ❑ Cancer ❑ Heart Condition ❑ Other: _____
If yes, please explain: _____

Past/current surgical History:

❑ No history of surgery

❑ Ankle surgery L / R
❑ Elbow surgery L / R
❑ Hand surgery L / R
❑ Knee arthroscopy L / R
❑ Total hip replacement L / R
❑ Total knee replacement L / R
❑ Total shoulder replacement L / R
❑ Rotator cuff repair L / R
❑ Bypass
❑ Cancer
❑ Pacemaker
❑ Spine: _____

Medication:

❑ No Medication taken
❑ See provided list
❑ Steroids (i.e. prednisone)

❑ Anti-depressant
❑ Anti-anxiety
❑ Blood thinner
❑ Other:_____
❑ Hypertension
❑ Diabetes
❑ Heart Medication
❑ Pain Killer
❑ Anti-inflammatory
❑ Osteoporosis

Allergies:

❑ None/unknown
❑ Latex
❑ Other: _____

Patient Name: _____ **Signature:** _____ **Date:** _____

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