ascension
PHYSICAL THERAPY

6200 Lake Otis Pkwy, Suite 104, Anchorage, AK 99507 ph 907.770.6693 fx 907.770.6697

Name: _____ DOB: _____

Gender: M / F Pregnant: Y / N Tobacco: Y / N Occupation: _____

Referring Physician: _____

Past Surgical History (list all & date): _____

_____

Please List All Current Medication: _____

_____

Have you had an X-ray, MRI, CT, Nerve Conduction Velocity (NCV), EMG, or Myelogram? (Please circle)

If yes, please explain findings: _____

Have you been vaccinated for COVID-19? Y / N Type: Moderna / Pfizer / Johnson & Johnson

Have you received both injections? Y / N Date of last injection: _____

Past Medical History: Have you been told you have (or had?)

Cancer	Y N	Pace Maker	Y N	Lung Disease/Pneumothorax	Y N
Diabetes Type I or II	Y N	DVT/Blood Clot	Y N	Asthma	Y N
Kidney Disease	Y N	Used Corticosteroids?	Y N	Seizures/Epilepsy	Y N
Liver Disease	Y N	Osteoporosis	Y N	Ulcers	Y N
Anemia	Y N	Gout	Y N	Hernia	Y N
Stroke/TIA	Y N	Osteoarthritis	Y N	Thyroid Disease	Y N
High Blood Pressure	Y N	Rheumatoid Arthritis	Y N	Joint Replacement	Y N
Heart Disease/Heart Attack	Y N	Fibromyalgia	Y N	Recent Illness/Infection	Y N
Angina/Chest Pain	Y N	Migraines or Headaches	Y N	Covid-19	Y N
MRSA	Y N	Tuberculosis	Y N		

Are you currently experiencing?

Change in Health	Y N	Headaches	Y N
Unexplained Weight Changes	Y N	Poor Balance/Falls	Y N
Increased Pain at Night or Rest	Y N	Dizziness	Y N
Fevers/Chills/Night Sweats	Y N	Vision Difficulties	Y N
Weakness	Y N	Hearing Difficulties	Y N
Changes with Bowel/Bladder	Y N	Numbness/Tingling	Y N
Pain with Eating/Swallowing	Y N	Shortness of Breath	Y N
Difficulty Sleeping	Y N	Depression / Anxiety	Y N

Current Symptoms:

Why have you sought care today? _____

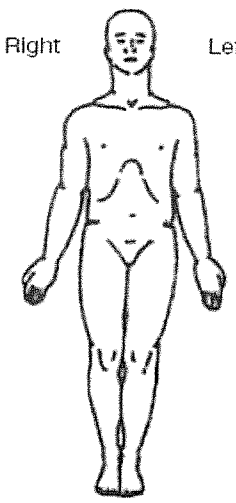
What date did your present pain begin? _____

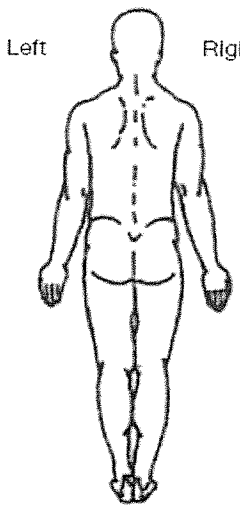
How (gradual, suddenly, an injury)? _____

Have you received any prior treatment for this problem? Y / N _____

What are your goals for physical therapy? _____

Do you have any allergies? ☐ None ☐ Latex Please List: _____





Please circle the number that best represents your symptoms

Average, for the past 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Best, for the past 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Worst, for the past 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Please mark areas on the body where you feel your symptoms.

Do you have pain or concerns about your bowel, bladder, or sexually related activities/ functions? Y / N

Are you taking blood thinner? Y / N

Do you have abnormal bleeding tendencies? Y / N

Do you have any known diseases or infections that can be transmitted through bodily fluids? Y / N

Do you have any metal implants or other implants (i.e. breast, calf, joint hardware, etc.)? If yes, please list:

_____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below as 0 (unable to perform) to 10 (able to perform activity at same level as before your injury/or problem).

1) _____

2) _____

3) _____

Rate your ability 0-10
Rating: _____
Rating: _____
Rating: _____