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| --- |
| Personal Information |
| Name:       | Date:      |
| Address:       City, State, Zip Code:       |
| Phone:       | (**[ ]** cell [ ]  home [ ]  office) | Email:       |
| DOB:       | Age:       |  |
| Emergency Contact:       | Phone:       | Relationship:       |
| How did you find Ascend?       |
| Health History |
| Please list any other health care practitioner(s) are you seeing:      |
| Occupation (including physical requirements/activities):       |
| Exercise Frequency:       | Exercise Type:       |
| Stress Level: [ ]  Low [ ]  Moderate [ ]  High |
| Caffeine Intake:      (#) drinks per [ ] day/[ ] week | Alcohol Intake:      (#) drinks per [ ] day/[ ] week |
| Do you smoke? [ ]  Never [ ]  Tobacco (current) [ ] Tobacco (past) [ ]  Marijuana (current) [ ] Marijuana (past) |
| Allergies:       |
| Have you ever been diagnosed with any of the following? |
| [ ] Heart Problems[ ] Hypertension[ ] Hyperlipidemia[ ] Arteriosclerosis[ ] Blood Clots[ ] Bleeding Disorder[ ] Anemia[ ] Circulation Problems | [ ] Lung Problems[ ] Asthma[ ] Tuberculosis[ ] Pneumonia[ ] Liver Problems[ ] Kidney Problems[ ] Gastrointestinal Problems[ ] Reflux/Ulcers | [ ] Cancer (type     )[ ] Diabetes (type     )[ ] Arthritis[ ] Autoimmune Disease[ ] AIDS/HIV[ ] STD [ ] Psychological Condition[ ] Depression or Anxiety | [ ] Stroke[ ] Concussion[ ] Migraines/Headaches[ ] Vision Problems[ ] Hearing Problems[ ] Vertigo[ ] Neurological Condition[ ] Musculoskeletal Problems |
| [ ] Other:       |
| Do you have a Pacemaker? [ ]  Yes [ ]  No | Are you pregnant? [ ]  Yes [ ]  No |
| Current Medications:      |
| Vitamins/Supplements:       |
| Past Injuries:       |
| Past Surgeries/Procedures:       |
| Current Condition |
| Symptom(s):       |
| Onset: (specific date if possible)       | (check one) [ ]  Gradual [ ]  Sudden |
| Mechanism or possible cause:       |
| Have you had similar symptoms in the past? [ ] No [ ] Yes If yes, how many times?       |
| Since onset are symptoms getting: [ ]  Better [ ] Worse [ ] Staying the same |
| As the day goes on, do your symptoms get: [ ]  Better [ ] Worse [ ] Stay the same [ ] Activity Dependent |
| Do your symptoms wake you from sleep? [ ]  No [ ] Only when changing positions [ ] When lying still |
| Do you have significant pain and/or stiffness upon waking in the morning? [ ]  Yes [ ] No |
| Have you had any of the following symptoms?[ ] Loss of bladder/bowel control [ ] Unexplained weight change [ ] Vision/hearing changes [ ] Numbness in genital area [ ] Fever or infection [ ] Dizziness/Fainting |
| Please rate your pain within the past 24 hours:At worst: [ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10Current: [ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10At best: [ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10How would you describe your pain?      | What aggravates your symptoms?     What relieves your symptoms?     Any prior treatment? (describe)     Any imaging or other testing? (type and results)      |
| What are your goals for physical therapy?       |