|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 10  Current: 0 1 2 3 4 5 6 7 8 9 10  At best: 0 1 2 3 4 5 6 7 8 9 10  How 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? | | | | | | | | | |