PENINSULA PHYSIOTHERAPY AND MASSAGE
BRENTWOOD PHYSIOTHERAPY AND MASSAGE

Date: ______________________________
Name: ______________________________ **DOB (yyyy-mm-dd):** ________________
Occupation: ________________________ **If retired, past occupation:** ____________

Are you latex sensitive? ❑ **Yes** ❑ **No** **Do you smoke?** ❑ **Yes** ❑ **No**

FOR WOMEN: Are you or could you be pregnant? ❑ **Yes** ❑ **No**

Do you have a pacemaker? ❑ **Yes** ❑ **No**

Have you recently noted any of the following? (check all that apply):

❑ Numbness/tingling: where?______________
❑ Muscle weakness: where?_______________
❑ Difficulty speaking
❑ Unexplainable weight loss 10+ lbs last 3 mth
❑ Pain with coughing or sneezing
❑ Changes in bowel or bladder function
❑ **Other:**_______________
❑ Dizziness/vertigo
❑ Double vision
❑ Shortness of breath
❑ Difficulty swallowing
❑ Fainting
❑ Nausea/Vomiting
❑ Changes in appetite
❑ Night Sweats
❑Shortness of breath
❑ Fever/Chills
❑ Falls
❑ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ Cancer
❑ Osteoporosis
❑ Upper respiratory tract infection
❑ Hemophilia or other bleeding conditions
❑ Circulation problems
❑ Kidney/Liver disease
❑ Osteoarthritis/Osteoporosis
❑ Chronic fatigue syndrome
❑ Recent bacterial infection
❑ Diabetes
❑ High/Low blood pressure
❑ Multiple sclerosis
❑ Rheumatoid arthritis
❑ Heart Disease/Angina
❑ Chemical dependency (i.e., alcoholism)
❑ Other: ______________
❑ Blood clots
❑ Stroke
❑ Hepatitis
❑ Parkinson's
❑ Fibromyalgia
❑ Bone infection

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches): If you have a pre-made list, simply let our front desk coordinator scan this document to save you time. ____
____

Have you ever taken STEROID medications? ❑ **Yes** ❑ **No** **If yes, for how long?** ______________

Have you recently taken OR currently taking blood thinning medications? ❑ **Yes** ❑ **No**

What are you coming in for today? ____

When did your symptoms start? ____

Have you ever had this problem before? ❑ **Yes** ❑ **No** **If yes, when?** ____________________

Previous treatment received? ____

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: ____/10
Your pain during the past 24 hours has been at its **BEST**: ____/10, and at its **WORST** ____/10

Do you consent to treatment today? ❑ Yes ❑ No Signature: ______________________________

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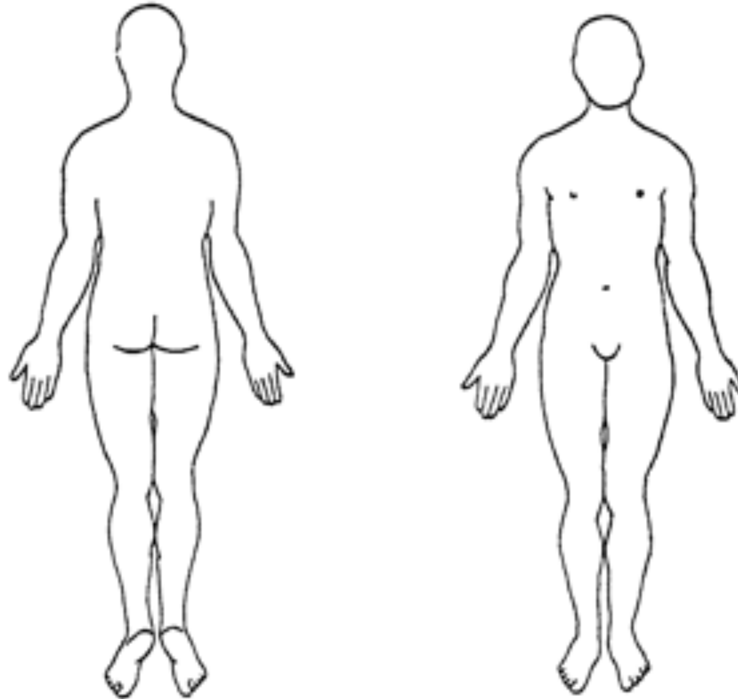
Patients Name: ______________________ **Date:** ______________________

Body Chart:



Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. ____
2. ____
3. ____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. ____
2. ____
3. ____

How are you currently able to sleep at night in regards to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep
❑ Awakened by pain ❑ Sleep only with medication

What position do you sleep in? ❑ Back ❑ Front ❑ RT Side ❑ LT Side

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise