



Medical Information Sheet



NAME: _____ AGE: _____ DATE: _____

PHYSICIAN: _____ DIAGNOSIS: _____

DATE OF INJURY: _____ METHOD OF INJURY: _____

MEDICATIONS: _____

CHECK ANY MEDICAL CONDITIONS THAT YOU HAVE BEEN TREATED FOR:

- Incontinence Cardiac Problems Pacemaker/Defibrillator Joint Replacement (list):
- Circulatory Problems High Blood Pressure Neurological Problems _____
- Stroke Diabetes _____
- Cancer Type of cancer: _____ Is it current? _____ _____

Have you received any therapy for this condition? _____ If yes, please explain: _____

What was your activity level prior to injury/surgery? Occupational: light moderate heavy N/A
 Recreational: light moderate heavy

What is your current activity level? Occupational: light moderate heavy N/A
 Recreational: light moderate heavy

Do you have trouble walking? _____ If yes, how far or for how long can you walk without pain? _____

Please review the following list of activities. Do you have trouble performing or are unable to perform any of these tasks? (check all that apply)

- Getting into/out of bed Eating Getting into/out of chair Sitting Driving
- Walking up/down stairs Walking Work related activities Standing Cleaning
- Bathing/Showering Doing Laundry Vacuuming Cooking Writing
- Getting into/out of shower Shopping Brushing your teeth Sleeping
- Getting into/out of car Dressing Personal Hygiene activities Shaving
- Other: _____

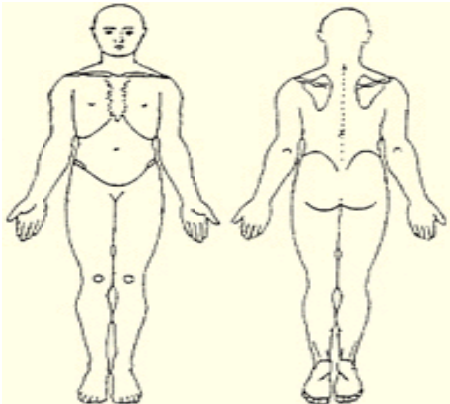
What is the location of the pain or discomfort we are seeing you for? _____

Please check if your pain/discomfort is: Constant Occasional
 Since initial injury/onset, has your pain: Improved Worsened

PLEASE RATE YOUR PAIN ON A SCALE OF 0 – 10.
 (0 = No Pain, 10 = The Most Pain Imaginable)
 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____
 Worse? _____

Signature: _____



Please use the body chart above to indicate the location of your symptoms: **XXX = PAIN** **OOO = NUMBNESS**