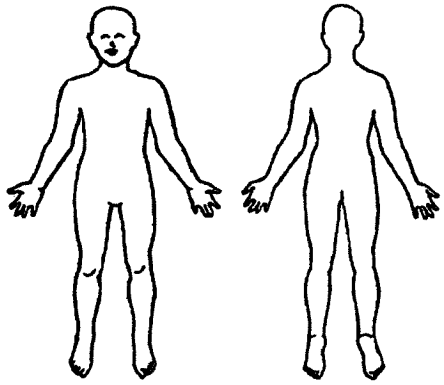
SW PHYSICAL THERAPY

503-597-1151
SWPHYSICALTHERAPY.COM
11910 SW GREENBURG RD.
TIGARD, OR 97223

Name _____ Today's Date _____
Hand Dominance: Right/ Left Occupation _____ Are you currently off work because of this problem? ☐Yes ☐No☐ Light Duty
When did your problems begin? _____
How did problems begin? _____
_____

Rate your pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Draw your pain:



Describe your pain: ☐Dull ☐Ache
☐Sharp ☐Stabbing ☐Pins & Needles
☐Shooting Pain ☐Burning ☐Throbbing
☐Twinge ☐Numbness/ Tingling
☐Other _____
Is your pain constant? ☐Yes ☐No
Intermittent? ☐Yes ☐No
Fluctuates with activity? ☐Yes ☐No
Wakes you up at night? ☐Yes ☐No

Have you had any previous treatment for your current condition? ☐Yes ☐No
If yes, please describe: _____

Are you currently being treated by any other physical medicine providers? Ex: Chiropractor, Acupuncture or Physical Therapist

_____

If so when did this take place? And where? _____

Any medical problems? ☐Yes ☐No
If yes, please explain: _____
_____

Please list ALL medications you are currently taking, prescription and over-the-counter, for this and any other conditions: _____
_____
_____

Have you ever had a history of any of the following? ☐Major injury to the head/ spine ☐Cancer/ Tumors ☐Osteoporosis ☐Dizziness/ Blackouts ☐Heart problems/ Angina ☐Diabetes ☐Pacemaker ☐Sudden weight loss/ gain ☐Severe pain at night
☐Smoking ☐Bruising easily ☐Asthma ☐Frequent falls ☐Loss of bowel/ bladder control ☐Numbness ☐Seizures/ Epilepsy ☐High blood pressure ☐ Coordination loss

I understand that the information I have provided will be held in the strictest confidence and that I have the right to view my records upon written request. I further understand that the Physical Therapy I receive is provided for the purpose to help you heal and