Rock and Armor Physical Therapy and Sports Performance

Name:_____ **Date:**_____
Last First MI

Gender: ____Male ____Female **Age:**_____

Please describe your condition or symptoms: _____

_____

Cause of the above:

_____Auto Accident _____Sports Injury _____On the Job Injury
_____Illness _____Unknown _____Other

Have you missed any work due to your condition? Yes No

Date your condition or symptoms began:_____

Initially seen for this condition on (date)_____ **by Dr.**_____

Please rate you pain level: no pain = 0 1 2 3 4 5 6 7 8 9 10 = worst pain

How would you describe your pain?

_____none _____dull ache _____deep ache _____stabbing
_____nagging _____throbbing _____squeezing _____drawing
_____burning _____heavy _____twinge _____cramp
_____sharp _____sore _____continual _____other

Do you have numbness or tingling? Yes No

If yes, where?_____

Prior to onset, were you free of these symptoms? Yes No **Explain**_____

What eases these symptoms?_____

What aggravates these symptoms?_____

Have you had any treatment for this condition? Yes No **Did it help?** Yes No

What type and where:_____

Since your last treatment, are you getting: better worse same

Have you had X-rays? Yes No **Findings:**_____

Please list any other tests you have received:_____

Please turn over ➘

Health History

What treatment have you already received for your condition? __Medications __Surgery __Physical Therapy ___Chiropractic ___None ___Other:_____

Name and address of other doctor(s) who have treated your condition:

_____

Date of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam _____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Please mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	(Yes)	(No)	Goiter	(Yes)	(No)	Pneumonia	(Yes)	(No)
Alcoholism	(Yes)	(No)	Gonorrhea	(Yes)	(No)	Polio	(Yes)	(No)
Allergy Shots	(Yes)	(No)	Gout	(Yes)	(No)	Prostate Problem	(Yes)	(No)
Anemia	(Yes)	(No)	Heart Disease	(Yes)	(No)	Prosthesis	(Yes)	(No)
Anorexia	(Yes)	(No)	Hepatitis	(Yes)	(No)	Psychiatric Care	(Yes)	(No)
Appendicitis	(Yes)	(No)	Hernia	(Yes)	(No)	Rheumatoid Arthritis	(Yes)	(No)
Arthritis	(Yes)	(No)	Herniated Disk	(Yes)	(No)	Rheumatic Fever	(Yes)	(No)
Asthma	(Yes)	(No)	Herpes	(Yes)	(No)	Scarlet Fever	(Yes)	(No)
Bleeding Disorders	(Yes)	(No)	High Cholesterol	(Yes)	(No)	Stroke	(Yes)	(No)
Breast Lump	(Yes)	(No)	Kidney Disease	(Yes)	(No)	Suicide Attempt	(Yes)	(No)
Bronchitis	(Yes)	(No)	Liver Disease	(Yes)	(No)	Thyroid Problems	(Yes)	(No)
Bulimia	(Yes)	(No)	Measles	(Yes)	(No)	Tonsillitis	(Yes)	(No)
Cancer	(Yes)	(No)	Migraine Headaches	(Yes)	(No)	Tuberculosis	(Yes)	(No)
Cataracts	(Yes)	(No)	Miscarriage	(Yes)	(No)	Tumors, Growths	(Yes)	(No)
Chemical			Mononucleosis	(Yes)	(No)	Typhoid Fever	(Yes)	(No)
Dependencies	(Yes)	(No)	Multiple Sclerosis	(Yes)	(No)	Ulcers	(Yes)	(No)
Chicken Pox	(Yes)	(No)	Mumps	(Yes)	(No)	Vaginal Infections	(Yes)	(No)
Diabetes	(Yes)	(No)	Osteoporosis	(Yes)	(No)	Venereal Disease	(Yes)	(No)
Emphysema	(Yes)	(No)	Pacemaker	(Yes)	(No)	Whooping Cough	(Yes)	(No)
Fractures	(Yes)	(No)	Parkinson's Disease	(Yes)	(No)	Other:	(Yes)	(No)
Glaucoma	(Yes)	(No)	Pinched Nerve	(Yes)	(No)	_____		

Exercise:
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity:
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits:
- ☐ Smoking
  Packs/day_____
- ☐ Drinking
  Drinks/week_____
- ☐ Coffee/Caffeine Drinks
  Cups/day_____
- ☐ High Stress Level
  Reason_____

Are you pregnant? _____Yes _____No Due Date, if applicable:_____

Allergies:_____

Injuries/Surgeries you have had with approximate date:_____
_____
_____

Contraindications to Treatment

Check if you have ever been diagnosed with any of the following conditions:

_____Recent scar tissue
_____Cancer, what type_____
_____Cardiac Pacemaker
_____Pregnant
_____Deep vein thrombosis
_____Hemophilia
_____Spinal fusions
_____Osteopenia/Osteoporosis
_____Diabetes
_____Rheumatoid Arthritis
_____Metallic implants
_____Defibrillator
_____Recent fracture
_____Arterial disease
_____Tuberculosis of lungs or bone
_____Spinal surgery
_____Insomnia
_____Other

If yes, please explain: _____

Doctor you are seeing for these conditions:_____

Please list or attach all prescription and over-the-counter medications you are currently taking.

_____

_____

Patient Signature:_____ **Date:**_____