ATTAIN
PHYSICAL THERAPY

Name: _____ Date: _____

Describe your pain, symptoms or anything regarding your chief complaint:

_____

_____

Check any that apply to you:	YES	NO	Check any that apply to you:	YES	NO
Neck Pain			High Blood Pressure		
Shoulder Pain			Weakness/Fatigue		
Hand/Wrist Pain			Thyroid Disease		
Low Back Pain			Asthmas		
Hip Pain			Joint pain and/or swelling		
Knee Pain			Stroke		
Ankle Pain			Seizures		
Foot Pain			Numbness or tingling, if yes where?		
HIV/AIDS			Weakness in your arms or legs		
Diabetes (high blood sugar)			Equilibrium Problems		
Low blood sugar			Difficulty walking		
Cancer			Heart Disease		
Arthritis			Chest pain		
Headaches			Blurred Vision		
Circulatory or vascular problems			Hepatitis		
Broken bones (fractures)			Swollen Ankles		
Surgeries			Fibromyalgia		
Multiple sclerosis/Parkinson ' s Disease			Tinnitus		
Varicose Veins			Osteopenia		
Difficulty Sleeping			Osteoporosis		
For men only:			Constipation		
Prostate disease			Skin Problem		
For women only:			Lyme's Disease		
Pelvic inflammatory disease			Lupus		
Endometriosis			Unusual Weight Gain		
Complicated pregnancies			Any significant family history of illness or disease		
Are you pregnant?			Other		

Elaborate on anything checked off with a YES:

_____

_____

List of Medications

Name of Medication	*Who Prescribed*	*Dosage*	*Frequency*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Imaging History:

_____

_____

Surgical History:

_____

_____

Social History:

Do you live alone? YES _____ NO_____ Do you drink alcohol? YES _____ NO_____

Do you have stairs in your home/apartment? YES_____ NO_____

Do you smoke/chew tobacco? YES_____ NO_____

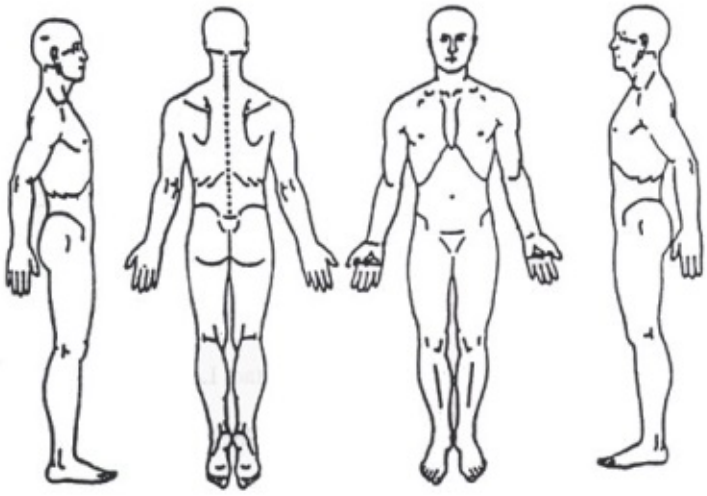
Are you the primary caregiver for any other person? YES _____ NO_____

Height: ____ft ____in Weight: _____lbs

Primary Care Physician's Name: _____

Area of Chief Complaint

(Please mark an X over the area of pain)



I certify that all information provided on this document is accurate to the best of my knowledge, and I understand that the Attain Physical Therapy LLC staff will be relying on this information to delivery the highest quality of care.

Signature: _____ Date: _____

Parent/Guardian (if under 18): _____ Date: _____