PROSPER | PHYSICAL THERAPY & DRY NEEDLING

Please help us serve you better by taking a few minutes to provide the following information.

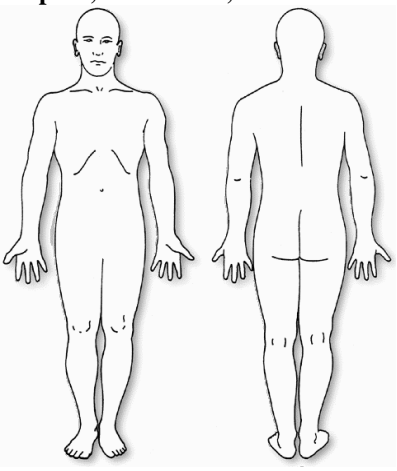
Name:				Today's date:	
Address:					
City / State / ZIP:					
Phone #	MOBILE				
DOB:					
Email:					
Occupation:					
Emergency Contact	Name:		Phone:		
Primary Care Physician	Name:		Date of next visit		
Specialist Physician	Name:		Date of next visit		

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	
At its worst	
At its best	
At present	
Night (sleeping)	

What activities increase your pain?	
What activities decrease your pain?	

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).	
Medication	**For treatment of**

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When