Shaul's Individualized Physical Therapy, PC
4123 Martin Road, Suite 201
Commerce Twp., MI 48390
Phone: (248) 366-9170 **Fax: (248) 366-9176**

****Please, fill all spaces. A lot of this is required by your insurance provider!**

WHEN DID YOU FIRST NOTICE YOUR PROBLEM? _____

DESCRIBE THE REASON FOR YOUR VISIT TODAY:_____

_____

ANY TREATMENT/S YOU HAD FOR THIS PROBLEM? _____

AVERAGE PAIN LEVEL (between 0 and 10) _____ is pain Constant? _____ Intermittent? _____

ARE SYMPTOMS WORSE IN…? AM _____ PM _____ NIGHTS _____ ACTIVITIES_____

HISTORY & PHYSICAL INFORMATION

AUTOMOBILE OR OTHER ACCIDENTS? _____

ANY DIAGNOSTIC TESTS? _____ RESULTS _____

SURGERIES? _____

HAVE YOU HAD PHYSICAL THERAPY BEFORE? ___ WAS THE OUTCOME FAVORABLE? _____

WHAT ARE YOUR EXPECTATIONS FROM THERAPY HERE? _____

Have you ever been diagnosed as having any of the following conditions? (Please check **only** the applicable)

Rheumatoid Arthritis	___	Cancer	___	Circulation	___	Depression	___
Other Arthritis	___	Asthma	___	Hepatitis/HIV	___		
High blood pressure	___	Anemia	___	Tuberculosis	___		
Stroke	___	Prostate	___	Heart disease	___		
Multiple Sclerosis	___	Epilepsy	___	Skin problems	___		
Diabetes	___	Foot discoloration/sensation problem			___		

Do you have/ have you experienced recently *SIGNIFICANT* problems with any of the following? (Please check **only** the applicable)

Fatigue	___	Weakness	___		
Allergies	___	Circulation	___	Sensation problem	___
Blackouts	___	Nausea	___	Shingles	___
Bowel/Bladder control	___	Dizziness	___	Pregnancy	___
Breathing	___	Headaches	___	Ears ringing	___
Chest pain	___	Jaw pain	___	Weight change	___
Vision disturbance	___	Pacemaker	___	Infection/Wounds	___
Incontinence	___	Constipation	___	Broken bones	___

Metal fixation (metal parts in your body) ____

Shaul's Individualized Physical Therapy, PC
4123 Martin Road, Suite 201
Commerce Twp., MI 48390
Phone: (248) 366-9170 **Fax: (248) 366-9176**

MEDICATION LIST (Please include drug's name, dosage, frequency and route)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

SOCIAL HISTORY

HEIGHT _____ WEIGHT _____ BMI (we will fill in this number!) _____
FALLS IN THE LAST YEAR YES_____ IF YES, HOW MANY? _____ NO_____
DID YOU INJURE YOURSELF? YES_____ NO_____
TOBACCO USE ____ ALCOHOL USE _____ DRUG USE _____
SCHOOL/WORK INVOLVES LONG STANDING PERIODS___ SITTING PERIODS__
WALKING DISTANCES___ DRIVING DISTANCES__