Initial Health Status

Patient Name:_____ **DOB:**_____ **Preferred Pronoun:**_____

Describe Your Current Condition and How It Began:_____

_____

_____

Onset Date/Surgery Date:_____ **Is this?** ☐ Work Related ☐ Auto Related ☐ Not Applicable

How often are your symptom(s) present (% of the day)?
☐Constantly (76-100%) ☐Frequently (51-75%)
☐Occasionally (26-50%) ☐Intermittently (0-25%)

How is your condition changing?
☐ Getting Better ☐Getting Worse
☐ Not Changing

Describe the nature of your pain:
☐Sharp ☐Dull ache ☐Numb ☐Shooting ☐Burning ☐Tingling ☐ Other _____

Current complaint (how you feel today): (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social, or household)?: (No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform any activities)

What 3 activities are most impacted by your condition? 1)_____
2)_____ 3)_____

Who have you seen for your condition before today (ie. VNA, Chiropractor, PT, Medical Doctor)? If yes, what treatments and when?

Have you had X-rays, MRI, and/or CT scan for your area of complaint? ☐Yes ☐No
Date(s) Taken:_____ **What body area(s) were taken?:**_____

Would you say your overall health right now is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Please check all the following that apply to you:

☐ Rheumatoid Arthritis
☐ Lupus/SLE
☐ Fibromyalgia
☐ Osteopenia/Osteoporosis
☐ History of falls
☐ Stroke/TIA
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Epilepsy/Seizures
☐ Concussion/Head Injury
☐ Headaches/Migraines
☐ Numbness/Tingling
☐ Difficulty sleeping
☐ Double Vision/Vision changes
☐ Difficulty Speaking or Swallowing
☐ Abnormal weight (Gain)/(Loss)
☐ Change in bowel/bladder function
☐ Pain unrelieved by position or rest
☐ Dizziness/Fainting
☐ Cardiac condition/Pacemaker
☐ High Blood Pressure
☐ High Cholesterol
☐ Shortness of Breath
☐ Diabetes
☐ Depression/Anxiety
☐ Currently Pregnant, # weeks: _____
☐ Cancer/Tumor: _____
☐ Other Health Problems (Explain):
_____
_____
☐ Surgeries: _____
_____
_____
☐ Current Medications (or provide list): _____
_____
_____
_____
_____

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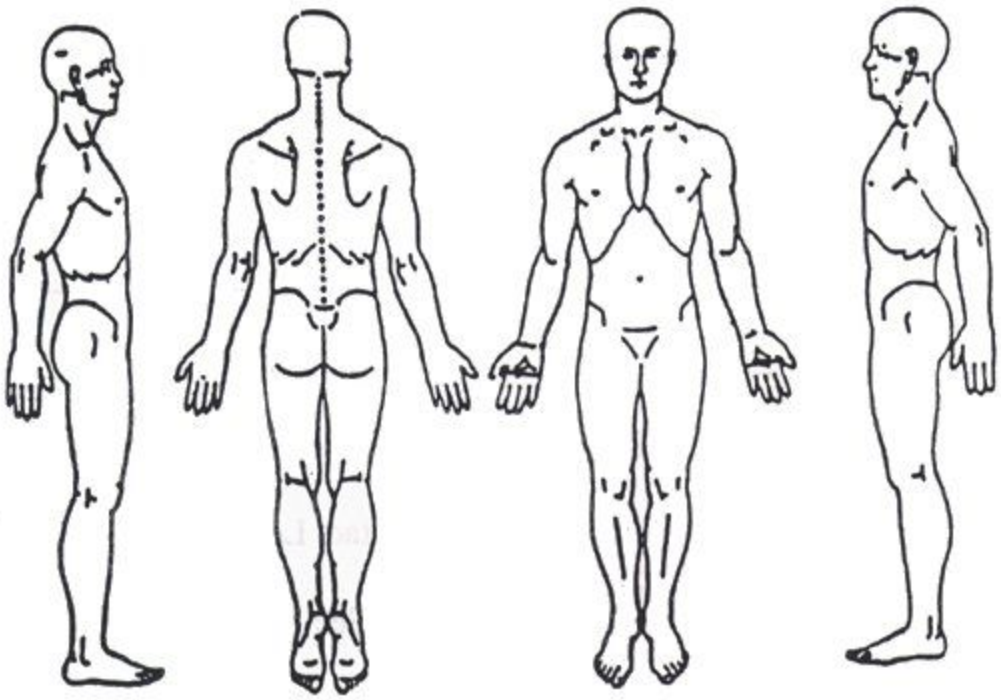
The following Chart lets us understand the location and nature of your symptoms.

1. Please use an **O** to indicate location(s) of PAIN.
2. Please use **X** marks to indicate where you feel NUMBNESS, TINGLING or BURNING.



Please complete the following and sign:

☐I certify to the best of my knowledge, the above information is complete and accurate.

☐I agree to notify this provider immediately when I have changes in my health condition in the future.

☐I understand that this provider may need to contact/consult my physician. Therefore, I give authorization to this provider to contact my physician, if necessary.

Patient/Responsible Party Signature:_____ **Date:** _____

The *Initial Health Status* was reviewed with the patient:

Physical Therapist/Athletic Trainer:_____ **Date:** _____