SUMMIT THERAPY & HEALTH SERVICES
CENTERED ON EXCELLENCE

***Please complete the following history to aid your therapist in your evaluation. This information will become part of your confidential records.***

**Name _____ Today's Date _____**

**Height _____ Weight_____ Age_____ Date of Birth_____**

**Reason for visit: _____**

**When did your condition start? _____ Occupation _____**

**Primary Doctor: _____ Referring Doctor: _____**

**How did you find out about Summit Therapy? _____**

**Have you had any imaging or testing for this condition? (X-ray, MRI, CAT scan, Blood Work) Describe: _____**
**_____**

**Are you currently taking any medications? If so, please list medication and the reason for taking:**
**_____**
**_____**

**Indicate if you have experienced the following with your current condition. Check those that apply.**

| | | |
|---|---|---|
| **_____ Blurred vision** | **_____ Dizziness** | **_____ Nausea/vomiting** |
| **_____ Dislocating** | **_____ Locking** | **_____ Giving way** |
| **_____ Pain with cough or sneeze** | **_____ Loss of consciousness** | **_____ Sudden loss of balance** |
| **_____ Bowel/Bladder problems** | **_____ Numbness/tingling** | |

**Indicate if you currently have or have had any of the following conditions. Check those that apply.**

| | | |
|---|---|---|
| **_____ Heart Disease** | **_____ Pacemaker** | **_____Diabetes** |
| **_____ Cancer** | **_____ Pregnancy** | **_____Asthma** |
| **_____ Seizures** | **_____ Lung problems** | **_____Blood Clots** |
| **_____ Clinical depression** | **_____Allergies** | **_____High Blood Pressure** |
| **_____ Stroke** | **_____Tumors** | **_____Low Blood Pressure** |
| **_____MRSA** | **_____Electronic Implant (Spinal, Neural, or Bladder Stimulator)** | |

**Other:_____**

**Indicate significant past medical history and approximate date**

| | | |
|---|---|---|
| **_____Neck/Spine** | **_____ Fracture** | **_____Dislocation** |
| **_____ Surgery** | **_____ Joint replacement** | **_____Other** |

**Describe:_____**
**_____**
**_____**

**1. Describe how and when your problem occurred: _____**
**_____**
**_____**

**2. Is this injury work related? ____Yes ____No**

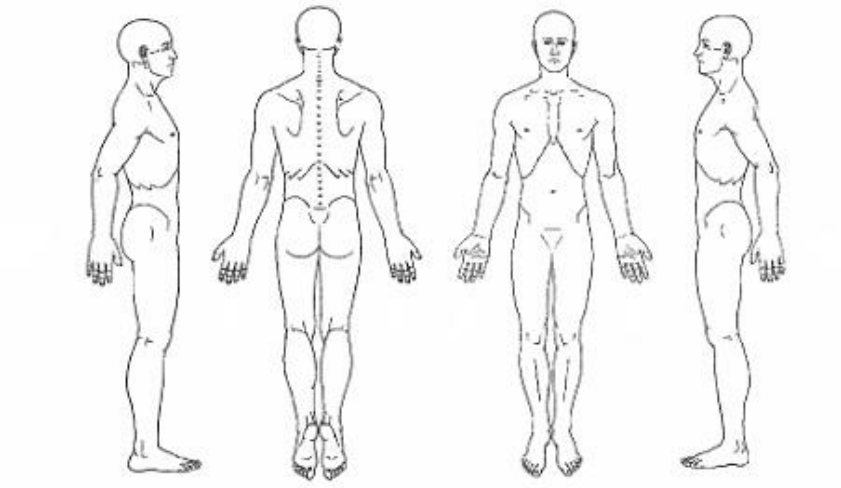
**3. Are the physical demands of your job: _____Light _____Moderate _____Heavy**

**4. What job tasks are affected by your injury? _____**
**_____**

Please Complete Page 2 on Back

**5. Indicate in the picture below where you are experiencing pain.**

**Right Back Front Left**



**6. Mark on the scale your current level of discomfort.**

**0**_____**5**_____**10**

***0=no pain 10=pain so intense you need to go to the ER***

**7. Do your symptoms wake you from sleep? ___Nightly ___Often ___Occasionally ___Never**

**8. As the day progresses, do your symptoms: ___Improve ___Worsen ___Stay the Same**

**9. Is your condition: ___ Improving ___ Getting Worse ___Staying the Same**

**10. Please circle what activities increase your symptoms.**

| | | | | | |
|---|---|---|---|---|---|
| **Sitting** | **Standing** | **Walking** | **Reaching** | **Lifting** | **Bending** |
| **Twisting** | **Squatting** | **Stairs** | **Driving** | **Computer** | **Kneeling** |
| **Lying** | **Prolonged position** | | **Other:**_____ | | |

**11. Please circle what eases your symptoms.**

| | | | | | |
|---|---|---|---|---|---|
| **Sitting** | **Standing** | **Lying** | **Walking** | **Movement** | **Rest** |
| **Bending** | **Medication** | **Other:**_____ | | | |

**12. Have you had a similar problem in the last several years? If yes, please describe: _____**

_____

_____

**13. Describe any treatment you have received for this condition: _____**

_____

_____

**14. What are your goals and expectations for therapy?**_____

_____

_____ **Date:**_____

**Signature**