

Professional Therapies, Inc.

Roanoke Vinton Daleville Rocky Mount Moneta Hardy Christiansburg Blacksburg Shawsville

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

Occupation: _____

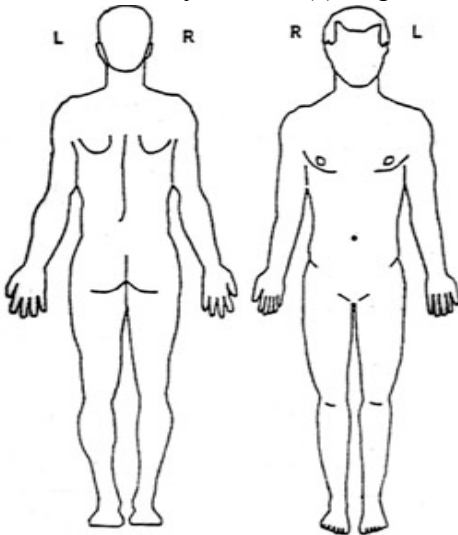
Leisure Activities: _____

Referring Physician: _____

Current Problem or Reason for Therapy: _____

Date of Injury or Beginning of Problem: ___/___/___ Is this the result of a Work Injury or Car Wreck?
(Please circle if appropriate)

Please mark your area(s) of pain:



Numeric Scale	Description
10	Worst possible
9	
8	
7	
6	
5	
4	
3	
2	
1	
0	Absolutely no discomfort

Have you ever had therapy before? YES NO

If yes: When: _____

Where: _____

Why: _____

Please list any other medical professionals you are currently seeing: _____

Do you have a history of any of the following?

Check, if yes	Condition	Check, if yes	Condition	Check, if yes	Condition
	Cancer (type _____)		Diabetes		Hepatitis
	Thyroid Disease		Seizures/Epilepsy		Headaches/ Migraines
	High Blood Pressure		Multiple Sclerosis		Breathing Problems
	Kidney Disease		Gall Bladder Disease		Swallowing Problems
	Circulation Problems		Depression		Night Pain
	Heart Disease		Neuropathy		Fibromyalgia
	High Cholesterol		Osteoarthritis		Rheumatoid Arthritis
	Tuberculosis		Stroke		Anemia

If you answered yes to any of the above conditions, please explain: _____

If you have had any surgeries please list: _____

Allergies: _____ Latex Sensitivity? YES NO

What, if any, limitations do you have with daily activities? _____

Do you ever feel unsafe at home? YES NO

Do you smoke? YES NO If yes, how much per day? _____

WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Date of your last pelvic exam: ___/___/___

Please list all current MEDICATIONS:

_____ taken for: _____

_____ taken for: _____

_____ taken for: _____

_____ taken for: _____

_____ taken for: _____

_____ taken for: _____

_____ taken for: _____

_____ taken for: _____

Have you recently been experiencing:

Weight Loss/Gain YES NO

Unusual Weakness YES NO

Nausea/ Vomiting YES NO

Fever/Chills/Sweats YES NO

Fatigue YES NO

Numbness/Tingling YES NO

Patient Signature: _____ Date: _____