PREMIER
PHYSICAL THERAPY & SPORTS MEDICINE

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☐ Jensen Beach Ph. (772) 324-3081 • Fax (772) 232-6282

Name:_____ Age:_____Occupation:_____Date:_____

1. When did your present pain start?

_____

2. How did your pain start?

☐ Suddenly ☐ Pulling
☐ Gradually ☐ Injured at work
☐ Lifting ☐ Injured in auto accident
☐ Twisting ☐ Hit from behind
☐ Falling ☐ Sports injury
☐ Bending ☐ Unknown

3. What makes it worse?

☐ Sitting ☐ Bending forward
☐ Standing ☐ Bending backwards
☐ Walking
☐ Other _____

4. What reduces the pain?

_____

5. Have you had any of these diagnostic studies?

☐ X-ray ☐ MRI
☐ CT Scan ☐ EMG
☐ Discogram ☐ Arthogram

6. What were the results of the diagnostic studies?

_____
_____
_____

7. Have you received treatment for this condition?

☐ No
☐ Yes
☐ Physical Therapy ☐ Injections
☐ Chiropractor ☐ Surgery
☐ Pain Management

Please Describe: _____
_____
_____

8. Do you have any of the following conditions?

☐ Heart ☐ Diabetes
☐ Blood Pressure ☐ Cholesterol
☐ Cancer ☐ Arthritis
☐ Metal Implant ☐ Pregnant
☐ Recent Weight Loss ☐ Bowel or Bladder
☐ Pacemaker ☐ Other

If any checked above please describe:

_____
_____
_____

9. What medications are you taking?

_____
_____
_____
_____
_____

10. Do you smoke?

☐ No
☐ Yes How Much? _____Packs/Week

11. Do you consume alcoholic beverages?

☐ No
☐ Yes How Much? _____ Beverages/Week

12. Have you had any past surgical procedures?

☐ No
☐ Yes Please List:_____
_____
_____
_____

13. Have you recently been hospitalized?

☐ No
☐ Yes When and what for?_____
_____
_____
_____

14. Do you have any allergies?

_____
_____

By signing this document, I am stating I have read and agree to the above policies.

_____ _____
Signature Date