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

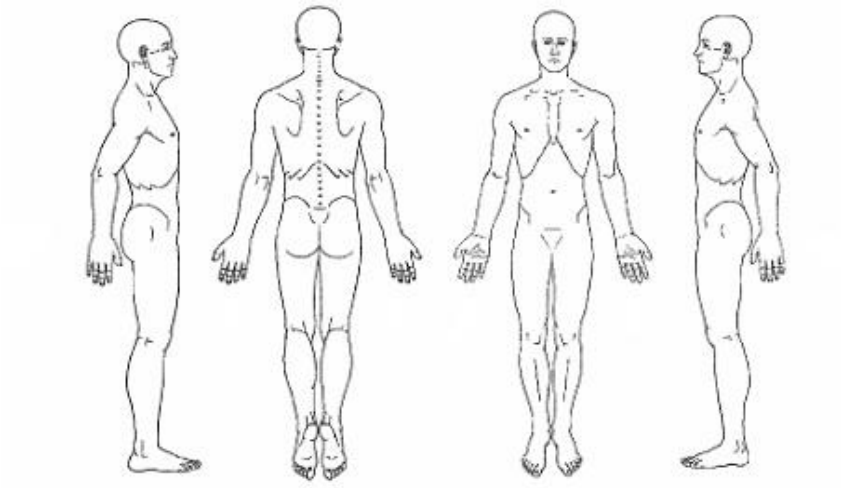
3. Are the physical demands of your job: _____Light _____Moderate _____Heavy

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