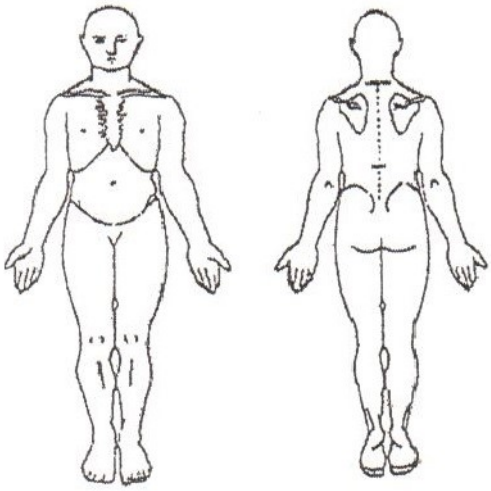
PTPRO
FOCUSED PHYSICAL THERAPY

BODY CHART

Please Mark Area of Pain



Patient Name:

Date:

Age:

Type of Injury/Condition:

Onset/Injury Date:

Occupation:

Sports Activities/Exercise:

Type of Surgery & Date (if any):

Next Doctor's Appointment (if known):

Describe any previous treatment for this condition:

Please check any tests you have had:

☐ X-Ray ☐MRI ☐EMG ☐CT Scan ☐Ultrasound

If so, what were the findings?

Have you recently noted:

☐Unexpected Weight Loss/Gain
☐Nausea
☐Vomiting
☐Dizziness
☐Fatigue
☐Weakness
☐Numbness/Tingling
☐Fainting
☐Pain at Night
☐Difficulty Swallowing/Speaking
☐Stumbling While Walking
☐Pain with Coughing/Sneezing
☐Changes in Bowel/Bladder Habits
☐Change in Vision or Double Vision
☐Numbness/Tingling in the Saddle Area
☐Numbness/Tingling in both Hands and Feet at the Same Time

Do you have now or have you ever had any of the following:

☐Surgeries
☐Sprains/Strains
☐Fractures
☐Loss of Consciousness
☐Cancer
☐Allergies/Skin Sensitivity
☐Pregnancy
☐Diabetes
☐Blood Pressure Problems
☐Heart Problems
☐Indigestion/Heartburn
☐Circulation Problems/Blood Clots
☐Asthma/Breathing Problems
☐Osteoporosis/Osteopenia
☐Easy Bruising/Bleeding
☐Motor Vehicle Accident

Please explain and give approximate dates for any items listed above:

Are you currently taking any medications? ☐Yes ☐No Name or Type of medication:

Type of Pain: ☐Sharp ☐Burning ☐Aching ☐Tingling ☐Numbness ☐Other

Rate your pain (1-minimal, 10-severe) Now _____ (0 to 10) At its Worst _____ (0 to 10) At its Best _____ (0 to 10)

What are your goals from Physical Therapy?