1460 Drew Avenue, Suite #200
Davis, CA 95618
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www.physicaledge.net

PATIENT:_____/AGE_____

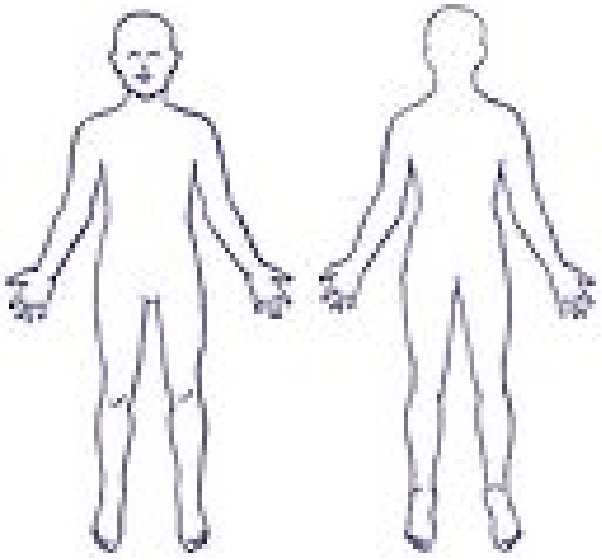
REASON FOR TODAY'S VISIT

What is primary reason for today's visit:

_____

***Please mark with an "x" the body part's involved**

Front **Back**



What are your goals with physical therapy?_____

_____

Patients Primary Care Physician:_____

Please check all other types of treatment you have tried for this condition:

Physical Therapy	Chiropractic
Acupuncture	Massage
Osteopathic	Homeopathic

Other (please specify)_____

Patient Signature:_____Date:_____

MEDICAL HISTORY

(All information remains strictly confidential)

Please circle any conditions **YOU** currently have or have had:

Diabetes	Stroke	Heart Disease
Cancer/Tumors	Lung Problems	Stomach Problems
Kidney Problems	Liver Disease	Arthritis
Joint Problems	Seizures	Nervous Disorders
Herniated Discs	Osteoporosis	Frequent Headaches
Eye Problems	Allergies	High Blood Pressure
Emphysema	Fracture	Parkinson's Disease
HIV/AIDS	Asthma	Epilepsy

Please list **ALL** current MEDICATIONS:

_____

_____

_____

Please list any know ALLERGIES:

_____

Please list previous SURGERIES:

_____

_____

_____

PHYSICAL / OCCUPATIONAL THERAPIST COMMENTS:

_____

_____

_____

_____

_____

_____

_____

Physical Edge Pain Diagram

For Therapist Use Only –

Pain Scale: 0 = No Pain 10 = Worst Possible Pain

Current: _____/10 Best: _____/10 Worst: _____/10

Aggravating Factors:

_____

_____

_____

_____

Easing Factors:

_____

_____

_____

_____

24 Hour Behavior

Additional Notes:

_____

_____

_____

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_____

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