Patient Information

Name ______________________ D.O.B. ______________ Date ______________

Diagnosis ______________________ Onset Date or Surgery Date ______________________

Current Medications ____

Previous Treatment for this Problem ____

Other Medical Problems (check applicable)

☐ Asthma	☐ Cardiac Condition	☐ Diabetes	☐ Arthritis
☐ Fibromyalgia	☐ Hypertension	☐ Osteoporosis	☐ Stroke
☐ Cancer	☐ Migraine Headaches	☐ Back or Neck	☐ Other ______________

Easing Factors ____

Aggravating Factors ____

Functional Limitations (What aren't you doing because of the current condition?) ______________________

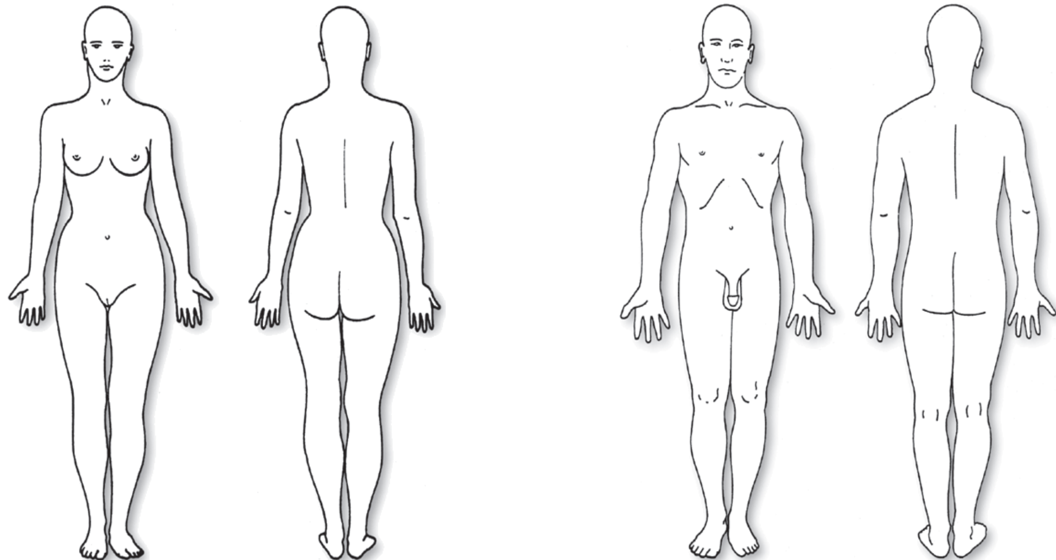
Goal of Treatment ____

Occupation ____

Sports, Hobbies, Recreational Activities ____

Other Pertinent Information ____

Please mark area(s) of symptoms on diagram



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