

- Walking _____
- Reaching behind back
- Sleeping
- Squatting
- Looking up overhead
- Sustained bending
- Lying down
- Swallowing
- Chewing
- Stress
- Up/down stairs
- Up/down an incline
- Vacuuming
- Doing dishes
- Making the bed
- Sports/recreation activities such as _____
- Other _____

13. What relieves / lessens your symptoms?
- Sitting
 - Standing
 - Lying down
 - Changing positions
 - Rest
 - Alcohol
 - Exercise
 - Heat
 - Cold
 - Nothing
 - Stretching
 - Massage
 - Other: _____

14. What previous treatment have you had?
- None
 - Physical Therapy
 - Bracing/taping
 - Medication
 - Injections
 - Exercise
 - Traction
 - TENS unit
 - Massage therapy
 - Manipulation/adjustment by a Osteopath or Chiropractor
 - Other _____

15. Have you had any of the following?
- X-rays
 - MRI
 - CT Scan
 - Arthrogram
 - Other: _____

16. Are you currently working? Yes No Part-time Full-time Restricted duty
Occupation (specific) _____

17. What positions are you in while working?
- Standing
 - Sitting
 - Walking
 - Bending
 - Lifting lbs _____ Frequency _____

18. Please list any activities that you can't do now because of your injury / symptoms:

19. What goals would you like to achieve from therapy? _____

20. Have you had, or do you currently have, any of the following medical conditions?
- Cancer
 - Heart Disease
 - Pacemaker
 - High Blood Pressure
 - Diabetes
 - Breathing difficulties
 - Pregnant – current
 - Bone and joint disorders
 - Recent surgery (this year)
 - Joint Replacement
 - History of seizures
 - Medications (Please list) _____

21. Past Medical History:

THERAPIST SECTION

22. How did the patient hear about us? _____
23. Patient has been made aware of diagnosis and prognosis. Yes No
24. Discussed goals with patient. Yes No **Functional Index Score:** _____

Therapist Signature: _____ Date: _____