



Ascend Sports & Orthopaedic Physical Therapy, LLC

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

Name:			Today's date:		
	Last Name	First Name			
Address:					
City / State / ZIP:					
Phone #	MOBILE		HOME		WORK
DOB:			Age:		Marital status: M S W D
Email:					
Occupation:			Employer:		
Emergency Contact	Name:		Phone:		
Primary Care Physician	Name:		Date of next visit		
Specialist Physician	Name:		Date of next visit		

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?	<p>Please shade in areas where you have pain, discomfort, or tension.</p>
Secondary concern/problem?	
As a result, I am now having difficulty with:	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	
When did your symptom(s) begin? (Date):	

Please rate your pain in the last 24-72 hours Using the “0 -10” scale where 0 is no pain and 10 is the worst possible pain.	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture)		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		Others (explain below)		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No
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Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?	Yes	No
Please Describe:		
In general, your lifestyle is:	1 Active	2 Average
	3 Average	4 Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

**List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".**

Task / Activity	Tolerance (minutes/hours)

I walk for		minutes before needing to rest
I stand for		minutes before needing to sit
I sit for		minutes before needing to change positions/get up
Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No