Physical therapy for the body, mind, and spirit
SPIRIT WINDS therapy

Confidential Medical History/Evaluation

Name	_____	Today's Date	_____
Street Address	_____	City, State, Zip	_____
Home Phone	_____	Cell Phone	_____
Email	_____	Date of Birth	_____
Emergency	_____	Phone	_____

Chief Complaint: _____ Date of Injury/Onset: _____

Current Symptoms:	Pain	Numbness	Stiffness	Weakness
Condition:	New	Acute	Chronic	

Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible. Indicate the severity of pain on a scale of 1 – 10. 0 = none and 10 = severe, excruciating pain.

Parasthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, etc.)

List any/all medications and dosage you are currently taking: _____

_____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative services for this injury? MRI XRAY

Other _____

Do you or have you had any of the following? Do you have pain when performing the following activities?

	YES	NO			Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema				Bending				
Shortness of Breath/Chest Pain				Care for Infirm Family				
Coronary Heart Disease				Carrying Groceries				
Do you have a pacemaker				Changing Position (Sit to Stand)				
High Blood Pressure				Changing Pos in Bed				
Heart Attack/Heart Surgery				Climbing Stairs				
Stroke/TIA				Driving				
Blood Clot/Emboli				Extended Computer Use				
Epilepsy/Seizures				Feeding (Self)				
Thyroid Trouble/Goiter				Household Chores				
Anemia				Kneeling				
Infectious Disease				Lifting Children				
Diabetes				Lifting				
Cancer or Chem/Radiation				Pet Care				
Arthritis/Swollen Joints				Reading/Concentration				
Osteoporosis				Self-Care Bathing				
Varicose Veins				Self-Care Dressing				
Gout				Self-Care Shaving				
Sleeping Difficulties				Sexual Activity				
Emotional/Psychological Problems				Sleeping				
Bowel or Bladder Problems				Sitting (Prolonged)				
Severe/Frequent Headaches				Walking (Prolonged)				
Vision/Hearing Difficulties				Yard Work				
Dizziness or Faintness				Sports				
Are you Pregnant				Recreational Activities				

Smoking: Daily Weekly N/A Exercise: Daily Weekly N/A

Alcohol Consumption: Daily Weekly N/A

Other Medical Conditions: _____

_____

_____