ACCELERATION PHYSICAL THERAPY

History and Interview

Patient Name:_____ Date_____

1. Date of the last visit to your doctor:_____
2. What is your primary problem?_____
3. When did your problem begin?_____
    a. Date of injury/Accident_____ Date of Surgery:_____
4. What activities make your symptoms worse?_____
5. What makes your symptoms better?_____
6. Do you have any type of cancer?_____
7. Are you/could you be pregnant? Yes_____ No_____
8. Do you have a pacemaker? Yes_____ No_____
9. Do you have any type of seizure disorder? _____
10. Past Medical History:_____

    _____

    _____
11. List **ALL** Allergies:_____
12. Do you wake up because of pain? Yes_____ No_____ # of times per night_____
13. What is your occupation/hobby?_____
14. What treatments have you had in the past?_____
15. Do you have any numbness/tingling/loss of sensation? Yes_____ No_____
16. What activities would you like to be able to do when you are done with physical therapy?

    _____

Please indicate your pain on this line:

No pain (0) Worst pain ever felt (10)

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Medications (including over the counters, vitamins, supplements)

Medication Name	Dose	How Often	How Taken (i.e. pill, injection)