NEWGEN

Name: _____ Primary Care Physician: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ○ Changes in appetite
- ○ Changes in bowel/bladder function
- ○ Difficulty maintaining balance while walking
- ○ Difficulty swallowing
- ○ Dizziness/lightheadedness
- ○ Fever/chills/sweats
- ○ Headaches
- ○ Nausea/vomiting
- ○ Pain at night
- ○ Shortness of breath
- ○ Weakness/fatigue
- ○ Weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ○ Anemia
- ○ Asthma
- ○ Cancer (type) _____
- ○ Chemical dependency (i.e., alcoholism)
- ○ Depression
- ○ Diabetes
- ○ Epilepsy
- ○ Heart disease
- ○ High blood pressure
- ○ Kidney/liver problems
- ○ Lung problems
- ○ Multiple sclerosis
- ○ Osteoporosis
- ○ Pacemaker inserted
- ○ Parkinson's disease
- ○ Rheumatoid arthritis
- ○ Stomach ulcers
- ○ Stroke
- ○ Thyroid problems
- ○ Other _____
- ○ Other _____

Have you RECENTLY been seen by a physical therapist in the past 12 months? If yes, when? _____

Do you smoke? Yes ☐ pack/day _____ No ☐

Current Medications:

_____

Blood thinners or anticoagulants? Yes ○ No ◉

Allergies: _____

Past Surgeries:

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **Yes** ☐ **No** ☐

FOR THE INJURY YOU ARE SEEING US FOR TODAY: ⬇

Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS

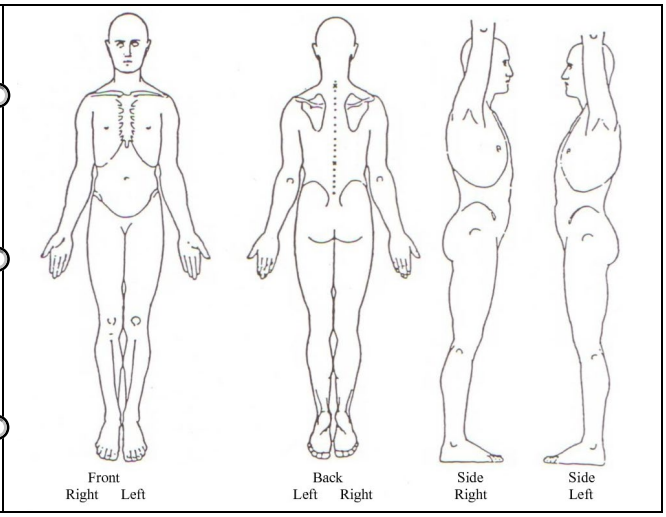
0 ◉ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○
No pain worst pain imaginable

Pain CURRENTLY: Rate your level of pain now.

0 ◉ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○
No pain worst pain imaginable

Pain at WORST: Rate our highest pain level IN THE PAST 3 days

0 ◉ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○
No pain worst pain imaginable



Description of location and type of pain: