Layton Physical Therapy Co., Inc.
Pre-Examination History and Injury Report

NAME:_____ DATE:_____

Have you had any falls in the past 12 months? ☐ Yes ☐ No If Yes, how many times?_____

If Yes, please describe the nature of the fall(s): _____

If Yes, please describe if any injury(ies) occurred: _____

Are there any factors that may complicate your ability to participate in therapy? ☐ Yes ☐ No If Yes, please explain:

_____

_____

_____

What were you doing prior to this injury that you are unable to do currently? _____

_____

_____

Do you exercise? ☐ No ☐ Moderately ☐ Daily ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Habits: ☐ Smoking # per day ____ ☐ Alcohol ☐ Coffee/Caffeine ____cups/day

Current Height:_____ Current Weight:_____

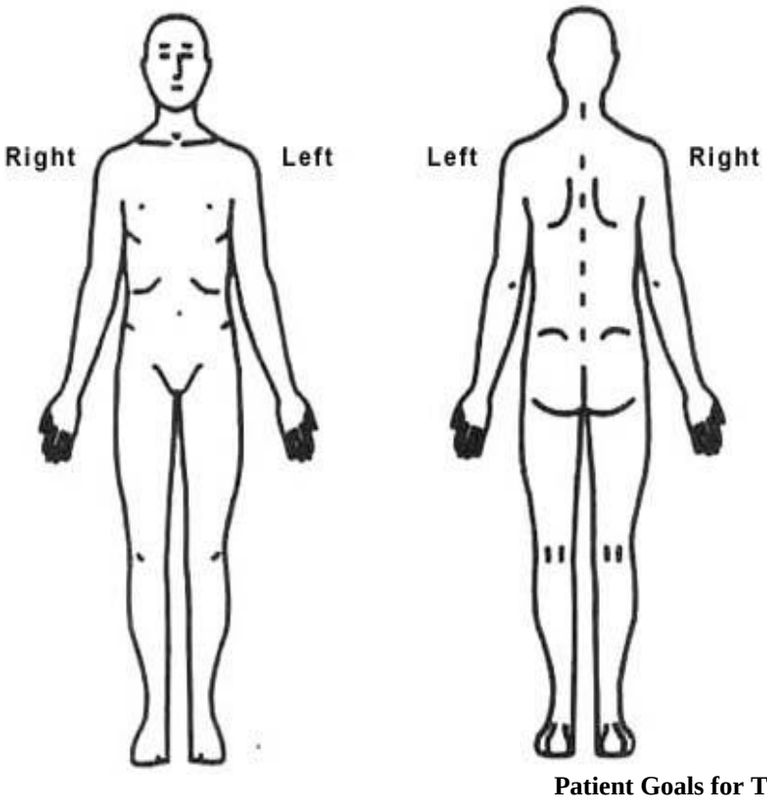
Please circle any of the following tests you have had concerning your present condition:

X-RAYS MRI CAT SCAN BONE SCAN EMG MYELOGRAM OTHER:_____

Date/Results of test(s): _____

_____

Please indicate pain on body diagram:



Describe your pain: (please circle)

Constant	Comes & Goes	Shifts
Deep	Superficial	Dull
Sharp	Stabbing	Aching
Cramping	Throbbing	Burning
Numbness	Tingling	Other:_____

Describe any activities that increase pain:

_____

_____

_____

_____

Describe activities that decrease pain:

_____

_____

_____

_____

Rate your pain:

0 = No Pain; 10 = Severe Pain

Pain Scale:

0 5 10

Patient Goals for Therapy

What are your goals for participating in therapy? _____

_____

_____

Patient Signature

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient Signature: _____ Date: _____