DARA WELLNESS & PHYSIO

Patient Name:_____ Date of Birth: _____

Address:_____

Phone Number:_____

Email Address:_____

Occupation/School:_____

Referring Doctor (if applicable):_____

Emergency Contact:_____

Phone Number:_____ Relationship:_____

How did you find out about Dara Wellness and Physio?

_____

What is the primary complaint that brings you here?

_____

Date of Onset:_____

What makes your pain worse?_____

What makes your pain better?_____

Check any of the following that accurately describe your symptoms:

___ Burning	___ Sharp	___ Dull/Ache	___ Throbbing
___ Numbness	___ Tingling	___ Shooting	_✔_ Electric
___ Vague	___ Full	___ Tight/Stiff	___ Constant

Other:_____

Have you had any diagnostic testing?

___ X-ray ___ CT Scan ___ MRI ___ EMG ___ None Other:_____

Describe the findings/results:_____

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Medical History (Please check all that apply):

___ Arthritis
___ Rheumatoid Arthritis
___ Autoimmune Disease
___ Asthma
___ Broken Bones
___ Depression/Anxiety/Bi-polar
___ Night Pain
___ Cancer
___ Unexplained Weight Loss
___ Seizures
___ Stroke/TIA
___ Cardiovascular Disease
___ Motor Vehicle Accident
___ High/Low Blood Pressure
___ High Cholesterol
___ Diabetes - Type 1 or Type 2
___ Thyroid Problems
___ Neurological Disease
___ Headaches
___ Dizziness
___ Shortness of Breath
___ Respiratory Disease
___ Osteoporosis/osteopenia
___ Bowel/Bladder Changes
___ Hearing Loss
___ Vision Loss

Other:_____

Please list your surgical history:

Allergies: _____

Current Medications:

Do you smoke? Yes_____ No_____

Average stress level: None_____ Mild_____ Moderate_____ Severe_____

Hours of sleep per night on average:_____

Have you fallen in the last year? Yes_____ No_____

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What are your goals for physical therapy?

_____

Patient Specific Functional Scale

Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your condition. Then rate each activity 0-10.

0 = unable to perform

10 = no difficulty with activity

Activity	Score
1.	
2.	
3.	

Printed Patient Name:_____

Patient Signature:_____

Parent/Guardian Signature (if patient is a minor):_____

Date:_____