



227 Central Ave | Christiansburg
757 University City Blvd | Blacksburg
1014 Clement St | Radford
www.totalmotionpt.net

Name: _____ Physician's Name: _____

CURRENT SYMPTOMS

Where are you currently having symptoms? _____

When & how did your symptoms/pain start? _____

My symptoms are currently (Circle One) Getting Better / Staying the Same / Getting Worse

Have you ever had this problem before? (Circle One) YES / NO

If so, how was the problem treated? _____

If so, how long did it take you to feel better? _____

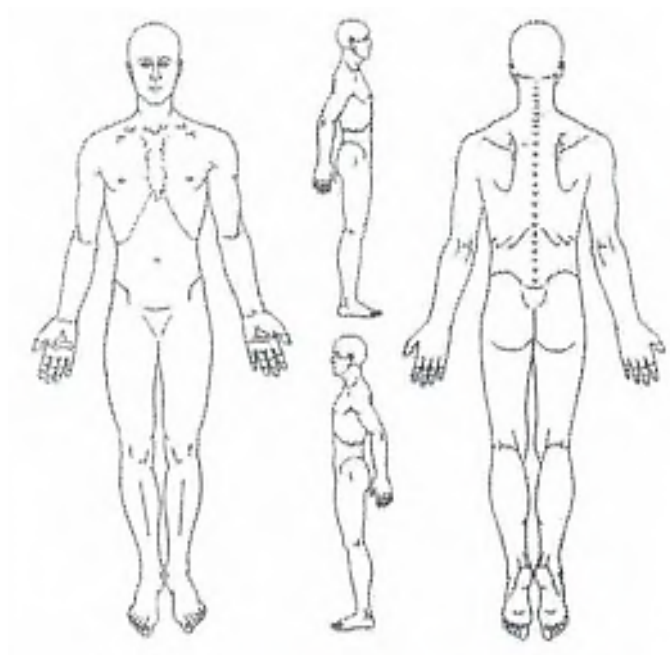
Are you sleeping well at night? (Circle One) YES / NO

Have you had an X-ray, MRI or other imaging/study performed? (Circle One) YES / NO

Are you currently under homecare services? (Circle One) YES/ NO If so for what? _____

BODY CHART

Please mark, on the chart below, the areas you feel symptoms and describe your pain: _____





227 Central Ave | Christiansburg
 757 University City Blvd | Blacksburg
 1014 Clement St | Radford
www.totalmotionpt.net

On the scales below, please circle the number which best describes the severity of your pain

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

PAST/CURRENT MEDICAL HISTORY (Please circle all that apply).

- Allergies Dizzy Spells MRSA
- Anemia Emphysema/Bronchitis Multiple Sclerosis
- Anxiety Fibromyalgia Muscular Dystrophy
- Arthritis Fractures Osteoporosis/Osteopenia
- Asthma Gallbladder Problems Parkinson's Disease
- Autoimmune Disorder Headaches Rheumatoid Arthritis
- Cancer Hearing Implants Seizures
- Cardiac Conditions Hepatitis Speech Problems Chemical Dependency
- High/Low Blood Pressure STD's Circulation Problems HIV/AIDS Strokes
- Currently Pregnant Incontinence Thyroid Disease Depression Kidney Problems Tuberculosis
- Diabetes Metal Implants Vision Problems



227 Central Ave | Christiansburg
757 University City Blvd | Blacksburg
1014 Clement St | Radford
www.totalmotionpt.net

Please note any medical conditions not listed above that you have or have had in the past:

Please list ALL CURRENT medications or attach a list:

Are you currently taking blood thinning or anticoagulant medication? YES /NO Latex Sensitive? YES / NO

Please list past surgical history, including dates:

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING? (Circle all that apply)

- Abnormal sensations Changes in Vision Constipation Easy Bruising Headaches
Light Headedness Night Sweats Unexpected weight loss/gain

What are your goals for physical therapy at this time?

Patient Signature: _____

Date: _____