



Healing in Motion

Anne Robinson PT, SEP
physical therapy/somatic experiencing

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Date: _____ Name: _____ DOB: _____ Age: _____

Occupation: _____ Work status: FT / PT / Retired / Not Working

Primary Care Physician: _____

Please bring any recent x-ray, MRIs surgical pictures, surgical report or other test results:

Please answer as fully as possible.

Date symptoms began? _____

List any recent surgery: _____

What was the cause of your current problem? _____

Have you had this before? _____ What helped you? _____

What are you doing to help yourself now? _____

Did the problem come on immediately or gradually? _____

How has your problem changed over the last 14 days? _____

What makes symptoms better? _____

What makes symptoms worse? _____

How do your symptoms change over the course of the day? _____

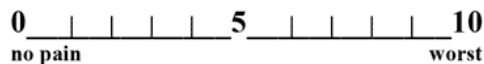
Can you sleep through the night and how? _____

What percentage of your normal functional ability are you at now? _____

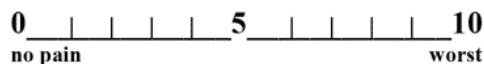
Do you normally exercise and how? _____

Please indicate pain range on scale

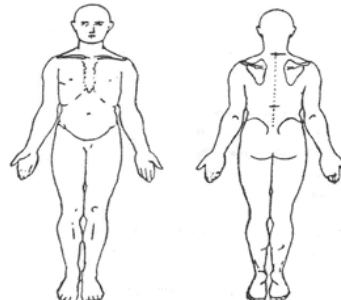
Your pain when you feel the best:



Your pain when you feel the worst:



Please draw areas of symptoms on diagram





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Check any of the following which you **cannot do** for **20 min** comfortably:

Sit	Walk	Normal Job Duties	Sleep	House Work
Stand	Drive	Carry 20 lbs.	Use Computer	Yard Work

Check any of the following you **cannot do** with your normal ability:

Climb Stairs	Move from sit to stand	Get in/out of car
Reach overhead	Move from floor to standing	Feed yourself
Lift 5-10 lbs. overhead	Pick 10-20 lbs. up from floor	Use utensils
Bathe and groom self	Move in bed	Chew
Dress yourself		

Personal Medical History – Check and describe when applicable

	Yes	No
Current Infection		
Cancer		
Hospitalization the last year		
Other		

Describe: _____
Describe: _____
Describe: _____
Describe: _____

	Yes	No
Heart problems or Pacemaker		
High Cholesterol		
Asthma		
Chemical Dependency		
Thyroid Problems		
Multiple Sclerosis		
Depression		
Tuberculosis		
Kidney Disease		
Epilepsy		
Osteoporosis or Osteopenia		
Pregnancy		
Chicken Pox, Shingles or Herpes		

	Yes	No
High Blood Pressure		
Circulation Problems		
Emphysema or Bronchitis		
Smoking		
Diabetes		
Rheumatoid Arthritis		
Other Arthritic Condition		
Metal Implants		
Hepatitis		
Stroke/TIA		
Anemia		
Allergies		
Heartburn or Esophageal Reflux		
Bowel or Bladder problems		



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Have you recently noted any of the following:

	Yes	No		Yes	No
Weight Loss			Shooting pain both arm or legs		
Nausea/Vomiting			Persistent Cough		
Fatigue			Dizziness		
Weakness			Headaches		
Fever/Chills/Sweats			Blurred Vision		
Numbness/Tingling			Blood in stool		

Please list all medications you are currently taking:

MEDICATION	DOSAGE	TIMES PER DAY	REASON FOR MEDICATION

Has your physician discussed your condition with you? _____

Signature

Date

Printed Name

Relationship