

# **BreakThrough**

## **PHYSICAL THERAPY**

*Newest Research, Fewest Visits, Best Results*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Briefly describe your current injury/symptoms: \_\_\_\_\_  
\_\_\_\_\_

Date of onset and cause of injury/symptoms: \_\_\_\_\_  
\_\_\_\_\_

Have you recently experienced any numbness, tingling, altered sensation in the arms, legs, trunk, or face? If so, where?  
\_\_\_\_\_

List any medications you are currently using and **for what purpose** (or provide the front office with a list of medications to photo copy): \_\_\_\_\_  
\_\_\_\_\_

Circle any of the medical conditions that apply to you: **Allergies, Pregnancy, Hemophilia, Anemia, Ulcer, GI disorder, Tuberculosis, Psychological disorder (i.e. Depression, Dementia, etc), Headaches, Severe Dizziness, Double vision, Kidney/Liver problems, Skin disease, Osteoarthritis, Rheumatoid arthritis, Cancer, Circulatory problems (i.e. PVD, clots, etc), High blood pressure, Diabetes, Pacemaker, Heart problems, Osteoporosis, Parkinson's, Alzheimer's, Multiple Sclerosis, Metal implants, Stroke, COPD (lung disorder), Back Disorder, Sciatica, Neuropathy, Nerve Disorder, or Pinched nerve**

Other medical conditions/disorders: \_\_\_\_\_

List any major surgeries and date: \_\_\_\_\_

List any brace/orthotic/ergonomic device you currently utilize: \_\_\_\_\_

List and date any tests relating to your present symptoms (ie X-ray, MRI, CT scan, EMG test, bone scan, etc) : \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_

What activities relieve your symptoms? \_\_\_\_\_

Approximate the amount of time you can tolerate: sitting \_\_\_\_\_, standing \_\_\_\_\_, and walking \_\_\_\_\_.

Occupation: \_\_\_\_\_

**Next Doctor's Visit:** \_\_\_\_\_

What functional activities (ie hobbies, home activities, sports, etc.) do you wish to resume?  
\_\_\_\_\_