Restor Physical Therapy P.O. Box 8125 Fountain Valley, CA 92728-8125
Office: 714-754-7268 Fax: 714-434-7042

Patient Name: _____ Date: _____

Chief Complaint/ Ailment / Injury: _____

Date of Injury: _____ Date of Surgery: _____

Briefly Describe How You Were Injured and Describe Pain Symptoms:

_____

Have You Received Therapy For This Condition? Yes or No When? _____
HOW MANY VISITS DID YOU RECEIVE? _____

Has Your Condition Been Getting: ___ Worse ___ Same ___ Better
Are Your Symptoms: _____ Constant or _____ Intermittent

Have you had surgery for this injury? Yes No Number of surgeries: 1 2 3 4 5 6

Type of surgery: _____

List of your **current** prescription and/or non-prescription medications: _____

_____

Have you had any of the following medical or rehabilitative services for **this** injury or episode?

	YES	NO		YES	NO
Physical Therapy	_____	_____	MRI	_____	_____
Massage Therapy	_____	_____	X-rays	_____	_____
Chiropractic	_____	_____	CT scan	_____	_____
Podiatrist	_____	_____	EMG/NCV	_____	_____
Neurologist	_____	_____	Myelogram	_____	_____
Orthopedist	_____	_____	Injections	_____	_____
Other _____					

Do you **Now** have ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/chest pain	_____	_____	Numbness or tingling	_____	_____
High Blood Pressure	_____	_____	Dizziness or Fainting	_____	_____
Epilepsy/Seizures	_____	_____	Bowel or Bladder Problems	_____	_____
Thyroid disease or Goiter	_____	_____	Weakness/Energy Loss	_____	_____
Anemia	_____	_____	Weight Loss/Gain	_____	_____
Diabetes/Type_____	_____	_____	Any pins or metal implants	_____	_____
Arthritis/Where_____	_____	_____	Emotional/Psychological	_____	_____
Osteoporosis	_____	_____	Are you pregnant?	_____	_____
Sleeping difficulties	_____	_____	Do you smoke?	_____	_____

Have you **EVER** had any of the following?

Coronary heart disease or Angina	_____	_____	Vision or hearing difficulties	_____	_____
Do you have a pacemaker?	_____	_____	Hernia	_____	_____
Heart Attack/	_____	_____	Varicose Veins	_____	_____
Stroke/TIA	_____	_____	Allergies	_____	_____
Congestive Heart Disease	_____	_____	Joint replacement surgery	_____	_____
Blood clot/Emboli	_____	_____	Neck injury/surgery	_____	_____
Infectious disease	_____	_____	Back injury/surgery	_____	_____
Cancer/Type _____	_____	_____	Shoulder injury/surgery	_____	_____
Gout	_____	_____	Knee injury/surgery	_____	_____
Ankle/foot injury/surgery	_____	_____	Elbow/hand surgery/surgery	_____	_____