the motive
PHYSICAL THERAPY SPECIALISTS

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

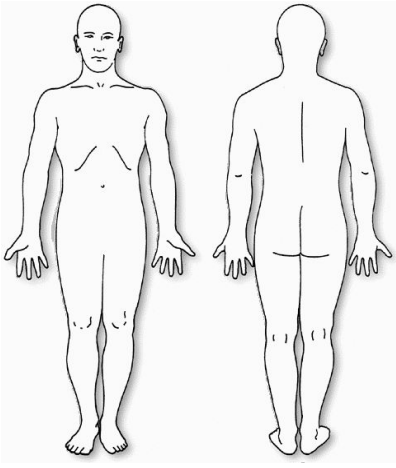
Name:	Last Name	First Name		Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Height / Weight									
SSN #:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



Please rate your pain in the last 24-72 hours **Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.**	At its worst	
	At its best	

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	At present	
	Night (sleeping)	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

List past medical history and dates of occurrence. General dates are okay. Include surgeries, accidents and other traumas going back to birth.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Do you have discomfort, shortness of breath, or pain with exercise?	Yes	No
Please Describe:		

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Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	Rate Difficulty, 0-10 (0= Unable to Perform, 10=Able to perform at same level as before injury)
1.		
2.		
3.		
Other Goals?		

Informed Consent

I understand that The Motive will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment only.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I understand that I retain the right to revoke this consent by notifying the practice in writing on this form or at any time.

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_____

Date:_____