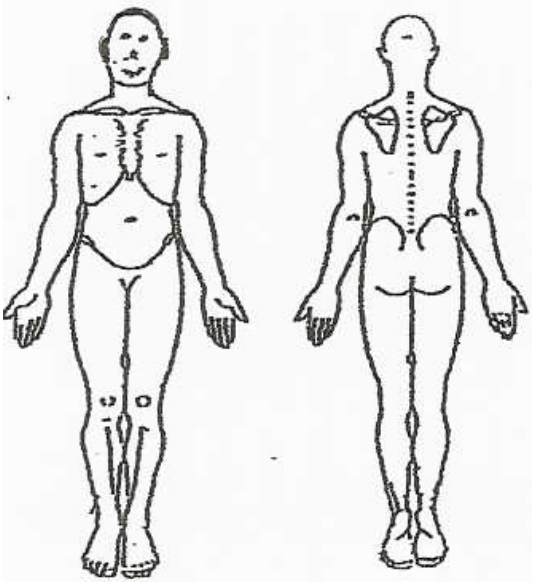
ProCare Physical Therapy

Please indicate the location of pain on the below diagram (Use key for detail)



KEY

X = Sharp/stabbing pain

O = Dull ache/throbbing

/// = Numbness/Tingling

Previous tests performed: (Please circle) ☐ MRI ☐ CT scan ☐ X-Ray

MRI Facility Name & Phone Number _____

Previous/Current treatment for condition: _____

_____

Please circle any of the following that you have had **OR** are currently experiencing:

☐ Heart problems	☐ Bowel/Bladder problems/Changes	☐ Respiratory problems
☐ Diabetes	☐ High blood pressure	☐ Low blood pressure
☐ Dizziness/Nausea	☐ Osteoporosis	☐ Pregnancy
☐ Blurred Vision	☐ Asthma	☐ Stroke
☐ Cancer	☐ Traumatic head injury	☐ Shortness of breath
☐ Fever (currently)	☐ Unexplained weight loss	☐ Depression

Current Medications: _____

Previous Surgeries: _____

Allergies: _____

Consent

Upon signing this informed consent authorized by *ProCare* Physical Therapy, I, the patient understand that rehab protocols are designed for maximum improvement in strength and function. Possible injuries or temporary flare-ups of symptom(s) may occur as a result of therapeutic activities. Treatments will be monitored by a qualified professional to maximize safety and minimize potential for injury. By signing this consent, I understand that I participate in treatments at my own risk and will follow the therapist's recommendations for optimal benefit.

_____ _____

Patient Signature Date