Cross Roads Physical Therapy, LLC
1187 S. Main St.
Woodstock, VA 22664
Phone: (540) 459-7660
Fax: (540) 459-7670
Director: Matt Shiffler

Helping You Know Which Way To Go

Name	Date of Surgery if applicable
Date	Describe cause of onset
Age	Occupation
Referred by	Leisure Activities
Diagnosis	Hand Dominance R L

Onset Date_____

What treatments are you having for this problem? _____

What treatment have you had in the past for this problem if applicable?_____

What are your symptoms now?_____

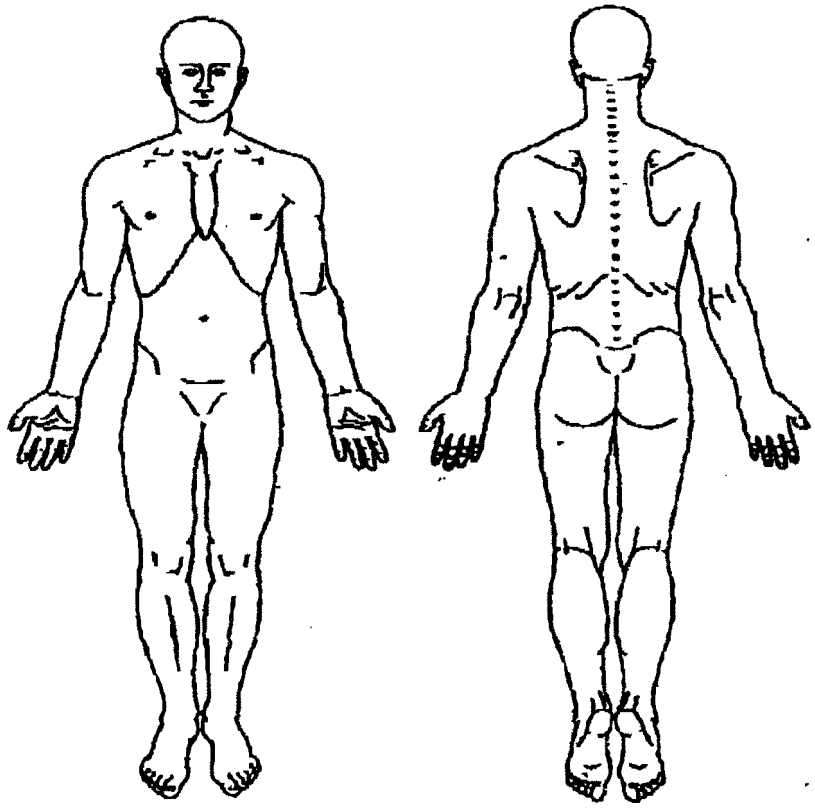
What are your goals for coming to PT?_____

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain.

KEY

/// Stabbing	XXX Burning	000 Pin and Needles	=== Numbness



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Make a mark (/) across the line to indicate how bad your pain is **today** between the extremes of "No Pain At All" and "Pain As Bad As It Could Be".

No Pain At All |_____| Pain As Bad As It Could Be

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date Injury

_____

_____

_____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Current Medications	Start date	Reason for taking

In the past 3 months have your had or do your experience:

A change in your general health?	YES	NO
Nausea / Vomiting?	YES	NO
Fever / Chills / Sweats?	YES	NO
Unexplained weight change?	YES	NO
Numbness or tingling?	YES	NO
Changes in appetite?	YES	NO
Changes in bowel or bladder functions?	YES	NO
Shortness of breath?	YES	NO
Dizziness	YES	NO
Upper respiratory infection?	YES	NO
Urinary tract infection?	YES	NO
Difficulty swallowing?	YES	NO

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems

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YES	NO	Asthma
YES	NO	Emphysema/Bronchitis
YES	NO	Chemical Dependency (i.e., alcoholism)
YES	NO	Thyroid Problems
YES	NO	Diabetes
YES	NO	Multiple Sclerosis
YES	NO	Rheumatiod Arthritis
YES	NO	Other Arthritic Conditions
YES	NO	Depression
YES	NO	Hepatitis
YES	NO	Tuberculosis
YES	NO	Stroke
YES	NO	Kidney Disease
YES	NO	Anemia
YES	NO	Epilepsy
YES	NO	Other