Freedom Therapy, 2050 South Clinton Avenue, Rochester, NY 14618

Client's Name	Referring Physician	MR#	DOB

Medical history

Please help your therapist better understand the problem or issue you're experiencing by answering the following questions. This information will be held in confidence and will be provided directly to your therapist. Thank you!

1) Please describe the problem or issue that you're experiencing or reason that brought you to Freedom Therapy:

_____

2) When did your symptoms begin?_____
Are your symptoms: ❑ improving ❑ worsening ❑ not changing

3) Have you had this problem for a long time? ❑ no ❑ yes
Have you had this problem in the past? ❑ no ❑ yes
If yes, please explain:_____

4) Have you had any treatment for this problem? ❑no ❑ yes, please describe:_____

_____

5) Did you recently have surgery? ❑ no ❑ yes, date of the surgery:_____
Name or type of the surgical procedure:_____
Have you had any surgeries in the past? ❑ no ❑ yes, please list:_____

_____

6) How do you describe your overall health: ❑ excellent ❑ good ❑ fair ❑ poor

7) Please mark any of the following conditions or diagnoses you have:

❑ alcoholism	❑ osteoporosis	❑ hypertension	❑ cancer	❑ fibromyalgia
❑ allergies	❑ respiratory issues	❑ pace-maker	❑ diabetes	❑ multiple sclerosis
❑ anemia	❑ depression	❑ immune issue	❑ seizures	❑ fracture
❑ arthritis	❑ drug abuse	❑ kidney problems	❑ stroke/TIA	❑ STDs
❑ asthma	❑ lymphedema	❑ liver problems	❑ urinary	❑ UTI
❑ bowel/GI	❑ heart disease	❑ mental illness	❑ vision	❑ Other:
❑ anxiety	❑ menopause	❑ dizziness	❑ heart attack	

Other(s):_____

_____

_____

8) Please list <u>all</u> medications that you're currently taking, including any non-prescription or over-the-counter medications and/or supplements, include the dosage and how often you take the medications and/or supplements:

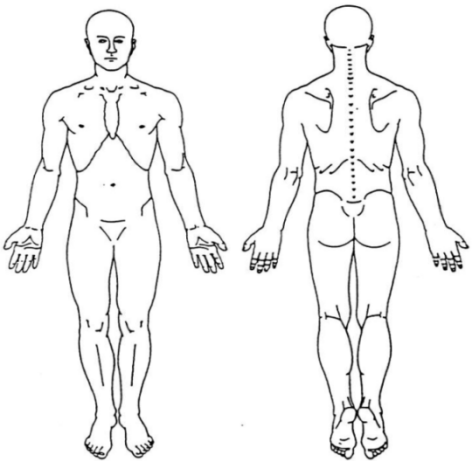
_____

_____

_____

Patient's Name	Referring Physician	MR#	DOB

9) If you're experiencing pain or discomfort, please circle the location(s) on this diagram:



Using a 0-10 scale, please rate your pain or discomfort
(0=no pain or discomfort, 10 = worst pain possible)

When your pain is at its "best": _____/10

When your pain is at its "worst":_____ /10

Average, most common pain level:_____ /10

10) Mark which boxes best describe your pain/discomfort: ❑ comes and goes ❑ constant ❑ tingling ❑ sharp
❑ ache ❑ burning ❑ shooting ❑ numbness ❑ other: _____

11) What other activities make your symptoms worse? _____

_____

12) What activities make your symptoms better? _____

_____

13) Are you currently working?
❑ No, due to: ❑ disabled ❑ retired ❑ other:_____
❑ Yes, occupation:_____ job duties:_____

14) Mark any activities that are difficult or that you're unable to participate in:
❑ walking ❑ standing ❑ sitting ❑ stairs ❑ squatting ❑ bending
❑ lifting ❑ carrying ❑ driving ❑ reaching ❑ kneeling ❑ exercise
❑ other:_____

15) Have you fallen in the past 12 months? ❑ no ❑ yes, how many times?_____
Did you sustain any injuries?_____
How did you fall?_____

16) Do you feel you can benefit from therapy to improve your problem and/or quality of life? ❑ yes ❑ no ❑ unsure

17) What are your goals for therapy?_____

18) Other comments:_____

Client's signature:_____ Date: ☐☐–☐☐–☐☐

Therapist's signature:_____ Date: ☐☐–☐☐–☐☐