Blake & Associates, Inc.
Physical Therapy

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Initial Medical Survey (IMS)

DATE_____ NAME_____

HEIGHT _____ WEIGHT _____ OCCUPATION _____

LEISURE ACTIVITIES _____

1) Please check any of the following whose care you're under:

_____	Medical Doctor (MD)	_____	Psychiatrist/Psychologist	_____	Podiatrist
_____	Osteopath	_____	Physical Therapist	_____	Other
_____	Dentist	_____	Chiropractor		
_____		_____			

If you have seen any of the above during the past 3 months, describe the reason:

_____

2) Please describe any significant injuries for which you have been treated including the approximate date of injury:

DATE	**INJURY**	**DATE**	**INJURY**
_____	_____	_____	_____
_____	_____	_____	_____

3) Please list any surgeries or conditions for which you have been hospitalized. Include an approximate date and reason for the surgery/hospitalization:

DATE	**REASON**	**DATE**	**REASON**
_____	_____	_____	_____
_____	_____	_____	_____

4) Have you EVER been diagnosed as having:

YES	NO	Cancer, if YES, describe what kind			
YES	NO	Heart problems	YES	NO	Rheumatoid Arthritis
YES	NO	High Blood Pressure	YES	NO	Other Arthritis
YES	NO	Circulation Problems	YES	NO	Depression
YES	NO	Asthma	YES	NO	Hepatitis
YES	NO	Emphysema/Bronchitis	YES	NO	TB
YES	NO	Chemical Dependency	YES	NO	Stroke
YES	NO	Thyroid Problems	YES	NO	Kidney Disease
YES	NO	Diabetes	YES	NO	Anemia

Please see reverse

Patient Name

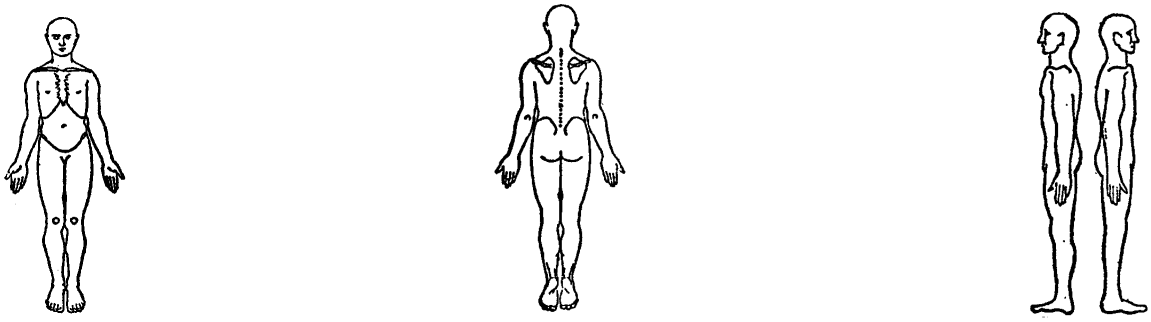
5) Please list any prescription medications you are currently taking: **(INCLUDE DOSAGE)**

How many caffeinated beverages do you drink a day?

How many days per week do you drink alcohol?

How many packs of cigarettes do you smoke a day?

6) Please mark where you have pain:



7) Have you recently noted:

YES	NO	Weight Loss/Gain	YES	NO	Weakness
YES	NO	Nausea/Vomiting	YES	NO	Fever/Chill/Sweats
YES	NO	Dizziness/Lightheadedness	YES	NO	Numbness or tingling
YES	NO	Fatigue	YES	NO	Trouble sleeping

8) Please circle your pain level in past 24 hours:

0 No Pain | 1 2 Annoying | 3 4 Uncomfortable | 5 6 Severe | 7 8 Horrible | 9 10 Excruciating

9) ALLERGIES: List all allergies, especially medications:

Are you latex sensitive? YES NO

10) What are your expectations of therapy?

Patient Signature Date

Therapist Signature Date