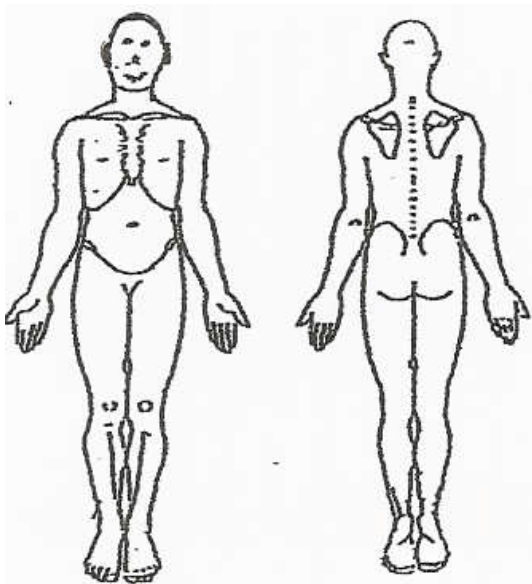


ProCare Physical Therapy

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