



Hillsdale Location: 5220 SW 17th Street | Topeka, KS 66604  
South Location: 2117 SW 37th Street | Topeka, KS 66611  
Phone: 785.271.5533 | Fax: 785.271.8818

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Physician: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Current Height \_\_\_\_\_ Weight \_\_\_\_\_  
What are we seeing you for today? \_\_\_\_\_  
Specific date of injury/onset of symptoms: (mm/dd/yy) \_\_\_\_\_  
How did it occur? \_\_\_\_\_  
List any previous treatments for this episode: \_\_\_\_\_  
Notes: \_\_\_\_\_

Past medical history: (please check)

High Blood Pressure	___ Yes ___ No	Osteoporosis	___ Yes ___ No
Heart Problems	___ Yes ___ No	Blood Clots	___ Yes ___ No
Neurologic Disorders	___ Yes ___ No	Diabetes	___ Yes ___ No
Pacemaker	___ Yes ___ No	Cancer	___ Yes ___ No
Are you pregnant?	___ Yes ___ No ___ Unsure	Seizures	___ Yes ___ No
Other: _____		Osteoarthritis	___ Yes ___ No

Surgery (list type) \_\_\_\_\_

Any recent health changes (i.e., significant weight gain/loss; bowel/bladder problems; fever; dizziness; changes in vision and/or speech, etc.)? \_\_\_\_\_

Are you taking any medications? (please list name, dosage, frequency, route administered ) \_\_\_\_\_

Allergies to tape/medications? (list) \_\_\_\_\_

Have you had any of the following tests for this specific incident? \_\_\_ CT scan \_\_\_ MRI \_\_\_ X-ray  
\_\_\_ EMG \_\_\_ Bone scan

1. Have you had physical therapy for this problem before? \_\_\_ Yes \_\_\_ No When? \_\_\_\_\_
2. Have you had any falls in the past year? \_\_\_ Yes \_\_\_ No When? \_\_\_\_\_
3. Have you been hospitalized in the past year? \_\_\_ Yes \_\_\_ No When? \_\_\_\_\_
4. Are you currently being treated by another healthcare provider? \_\_\_ Yes \_\_\_ No Who? \_\_\_\_\_
5. What is your level of activity prior to your injury? (circle one) High Moderate Low
6. Are you currently working? \_\_\_ fulltime \_\_\_ light duty \_\_\_ off \_\_\_ homemaker \_\_\_ N/A

(over)

15. What eases your pain? \_\_\_\_\_