restore
physical therapy

Date: _____

Name: _____ Age: _____ DOB: _____

Why are you here? _____
_____

What do you want to do now that you cannot currently do? _____
_____

Are you allergic to latex? Yes/No
Are you Right or Left handed?

General Health Questions:

Have you had ANY minor/major medical surgeries/procedures (brain, heart, organ transplants, broken bones, tumors, etc.) or previous/current health issues (cancer, diabetes, etc.)?

_____
_____
_____

Have you ever broken/sprained an ankle? Yes/No If yes, which one? Right/Left/Both
Do you have dizziness/vertigo? _____ Do you have migraines/headaches? _____
Do you have any jaw/neck/head issues? _____
Do you have any jaw popping/clicking/restrictions? _____
Do you clench/grind your teeth? _____
Do you have any ringing in/fullness of ears? _____
Have you ever had a concussion/head trauma/whiplash? _____
Do you have any breathing problems? (shortness of breath, snore, asthma, allergies, sleep apnea) _____
Do you have any foot problems? (flat feet, pain, bunions, calluses, hammer toes) _____
Do you wear any shoe inserts/orthotics/heel lifts? _____
Do you wear contacts/glasses or had Lasik? _____
Do you have or ever had any vision problems (double vision/lazy eye/eye turn), light sensitivity, or eye trauma/disease/surgery? _____
Have you had any major dental work done/worn braces/any teeth pulled/dental appliances?
_____

MARK THE LOCATION OF YOUR ISSUE(S):

PLEASE RATE THE LEVEL OF YOUR DISCOMFORT:

0 1 2 3 4 5 6 7 8 9 10

0= NO DISCOMFORT 10=EXTREME DISCOMFORT