## OUTPATIENT THERAPY SERVICES
### AMBULATORY SUMMARY LIST

**1. Check all the medical conditions or problems that apply to you:**

- Anemia
- Arthritis/gout
- Asthma
- Back trouble
- Cancer
- Chest pain
- Diabetic
- Fainting
- Fibromyalgia
- Fractures
- Head injury
- Heart disease
- Heart attack
- Hernia
- High blood pressure
- HIV / AIDS
- Kidney Disease
- Lupus
- Lung problems
- Metal/foreign implant
- Migraines
- Motor vehicle accident
- Multiple sclerosis
- Neuropathy
- Osteoporosis
- Pacemaker
- Parkinson’s disease
- Psychiatric treatment
- PVD
- Seizures
- Shortness of breath
- Stroke
- Swelling
- Tuberculosis
- Thyroid disease
- Other:

**2. List any surgeries or procedures that you have had:**

**List any previous therapy:**

**3. List current medications:**

**4. Allergies:**

**5. Do you smoke?** □ Yes □ No    **Are you pregnant?** □ Yes □ No

**6. Any significant weight gain/loss in the last year?** □ Yes (+ / -) __________ lbs □ No

**7. What is your occupation?**

**8. Reasons for being referred to therapy:**

**9. Describe the injury or onset of this condition:**

**Date of onset:**

**10. Please provide the results of any recent testing, X-rays, MRI, blood work, etc.**

**Patient Signature:** ___________________________  Date: __________________
11. Mark the location of pain on the picture.

12. Type of pain:
   - sharp
   - burning
   - aching
   - tingling
   - numbness
   Other: ____________________

13. Rate your overall pain on the scale:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO PAIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WORST PAIN</td>
</tr>
</tbody>
</table>

14. Does pain radiate into arms and legs?  □ Yes  □ No
   Does pain awaken you?  □ Yes  □ No

15. What aggravates your pain most:
   - sitting
   - standing
   - walking
   Other: ____________________

16. What positions or activities relieve or decrease your pain:

   ____________________________________________________
   ____________________________________________________

17. Does rest relieve pain?  □ Yes  □ No

18. Check all the activities that you have difficulty performing:
   - Sleeping
   - Shopping
   - Cooking
   - Cleaning
   - Sitting
   - Lifting
   - Bending
   - Kneeling
   - Squatting
   - Standing
   - Pushing
   - Pulling
   - Climbing stairs
   - Personal care (bathing, dressing, grooming)
   - Driving
   - Specific job duties: ____________________
   Other: ____________________
   Other: ____________________
   Other: ____________________

19. What do you expect to gain/accomplish in receiving therapy?

   ____________________________________________________
   ____________________________________________________

20. How did you hear about our clinic?  □ Doctor  □ Website  □ Friend  □ Publication
   □ Other: ____________________