SEL HEALTH CLINIC

Date: _____ Patient Name:_____ Date of Birth:_____ Age:_____

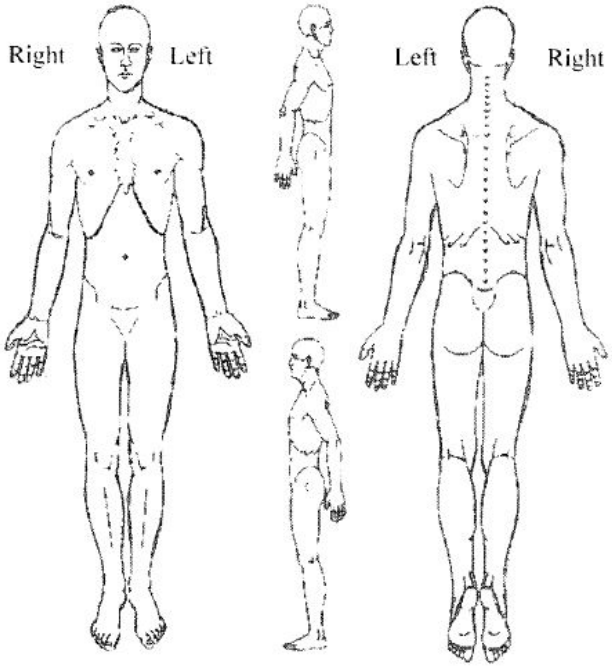
Occupation: _____Referred by: (Physician, Friend Etc.)_____

Please describe your problem (pain, numbness, stiffness, weakness) _____

_____

_____

On the picture below, please indicate the location of your pain, numbness, tingling etc.



On a scale of 0-10 **what is your pain level right now**?

_____

0 No pain Worst 10

On a scale 0-10 please rate your **level at best**?

_____

0 No pain Worst 10

On a scale of 0-10 please rate your pain **level at worst**?

_____

0 No pain Worst 10

What activities do you have difficulty with or stopped doing due to your symptoms?

1. _____
2. _____
3. _____
4. _____

When did your symptoms begin? (Indicate date if possible)? _____

Was the onset of this episode □ Gradual □ Sudden □ Chronic

Since the onset, are your symptoms getting: □ Worse □ Better □ No Change

Have you had similar symptoms in the past? _____

Have you or are you seeing any other healthcare providers for this current condition, if so who?

_____

Have you had any of the following tests: X-rays Ct Scan MRI If so where? _____

Physical Therapy "no-show" policy

I understand when I make an appointment for physical therapy that time is saved for me with a provider. I will inform the SEL Health Clinic at least 24 hours prior if I am unable to attend my scheduled appointment. If I miss an appointment, I understand that one attempt will be made to contact me to determine why I missed my appointment. After two cancellations or missed appointments without proper notice, all future physical therapy appointments will be cancelled.

If I am 10 or more minutes late to my scheduled appointment, I understand my appointment will be cancelled, and may be rescheduled. It is my responsibility to inform the SEL Health Clinic of an accurate phone number and my responsibility as the patient to reschedule any cancelled appointments.

Initials: **Date:**

_____ _____