

620 Elm Ave  
Norman, OK 73019-3146  
(405) 325-5710  
FAX: (405) 325-7553

Referring Provider: \_\_\_\_\_  
Script Expiration/ Frequency: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sooner ID #: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Injury? Yes No Auto Accident? Yes No

How did injury occur? \_\_\_\_\_

Surgery related to injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Please circle any imaging performed for this injury. *XRAY MRI CT SCAN* Date of imaging: \_\_\_\_\_

Current Medications: \_\_\_\_\_

What are your current symptoms? \_\_\_\_\_

What increases your symptoms? \_\_\_\_\_

What decreases your symptoms? \_\_\_\_\_

Have you received treatment for this condition? Please describe treatment (including self-treatment):

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What pain levels have you experienced in the past week (0 = no pain; 10= extreme pain)?

Lowest: \_\_\_\_\_/10 Highest: \_\_\_\_\_/10 Average: \_\_\_\_\_/10

Health History (Circle your answer to each question)

CANCER	YES	NO	COLD SENSITIVITY	YES	NO	
PACEMAKER	YES	NO	HEAT SENSITIVITY	YES	NO	
ARTHRITIS	YES	NO	NUMBNESS	YES	NO	
OSTEROPOROSIS	YES	NO	TINGLING	YES	NO	
HEADACHES	YES	NO	INCONTINENCE	YES	NO	
DIABETES	YES	NO	SEIZURES	YES	NO	
VISION LOSS	YES	NO	CIRCULATION ISSUES	YES	NO	
ANXIETY	YES	NO	HISTORY OF FRACTURES	YES	NO	
WEAKNESS	YES	NO	DIFFICULTY SLEEPING	YES	NO	
DEPRESSION	YES	NO	RECENT WEIGHT CHANGE?	GAIN	LOSS	N/A

If yes to any of the above, explain if necessary (I.E. cancer type, etc.):

Are you or could you be pregnant? YES NO

Do you have any other medical history?

What are your goals for physical therapy?

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_