HEALTH SERVICES
The UNIVERSITY of OKLAHOMA
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):

_____

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: _____