State of Franklin HEALTHCARE ASSOCIATES
*Your Health, Our Focus*

# PHYSICAL THERAPY

Date: _____

**Name:** _____

**Address:** _____

**Telephone Number:** _____

**Please list any surgeries you have had starting with the most recent:**

_____

_____

_____

**Do you have any of the following medical problems?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pacemaker | ( ) | Diabetes | ( ) | Kidney Problems | ( ) | Other | ( ) |
| Lung Problems | ( ) | Hepatitis | ( ) | Seizures | ( ) | | |
| Swelling | ( ) | High Blood Pressure | ( ) | Heart Disease | ( ) | | |
| Strokes | ( ) | HIV positive | ( ) | Tuberculosis | ( ) | | |
| Dizziness | ( ) | Arthritis | ( ) | Thyroid problems | ( ) | | |

**Do you have any allergies? Please explain**

_____

**Are you currently pregnant?**

_____

**Please list any medications you are taking:**

_____

_____

_____

_____

_____

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**PAIN ASSESSMENT**

**Are you currently having pain? ( ) YES ( ) NO If yes, describe:**

_____

_____

**How long have you had this pain?**

_____

**What eases this pain?**

_____

**What causes or increases the pain?**

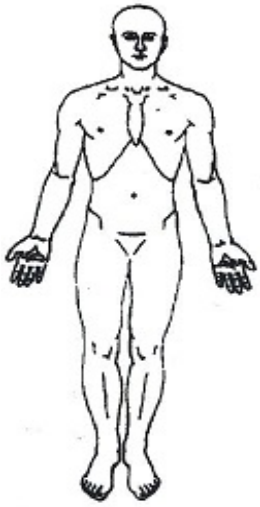
_____

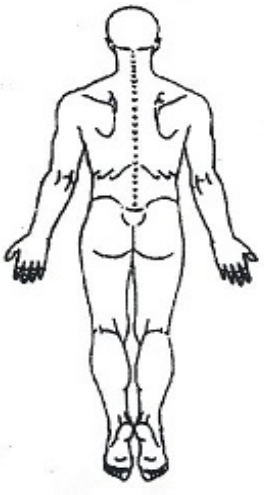
**Rate your pain on a scale of 1 to 10, with 1 being no pain and 10 the most severe pain. Please use an X.**

**{_____}**

**1 2 3 4 5 6 7 8 9 10**

**Mark these drawings according to where you hurt.**





**Advance Directive Form?** Yes ( ) No ( )

**Living Will Form?** Yes ( ) No ( )

(Blank forms are available in our waiting room)