COMPLIMENTARY CONSULTATION WORKSHEET

BODYWORKShfr.com

To help us assist you, please provide us with the information requested below.

Your Name: _____ Doctor's Name: _____

Visit Date: _____ Return To Dr. Date: _____

1. What health issue(s) are you being seen for today? Please provide a brief description below.

_____

_____

2. Have you undergone any testing for the problem for which you are being seen for today? (X-ray, MRI, EMG, CT Scan, etc) or treatments? ☐ Yes ☐ No. If you answered yes, please provide a brief description.

_____

_____

3. Are you currently taking any medications? ☐ Yes ☐ No If you answered yes, please list them below.

_____

_____

4. Do you have any other medical conditions for which you are currently being treated for? ☐ Yes ☐ No
If you answered yes, please provide a brief description.

_____

_____

5. Please indicate any other pertinent information or difficulties you feel are relevant to your visit today.

_____

_____

System Review – Clinic Use Only

	Not Impaired	Impaired
Cardiovascular / Pulmonary System (HR, RR, BP, Edema)	☐	☐
Integumentary System (Integrity, Scar Formation, Color)	☐	☐
Muscloskeletal System (Gross Strength, ROM, Symmetry)	☐	☐
Neuromuscular System (Balance, Gait, Locomotion, Transfers, Motor Function)	☐	☐
Communication System (Affect, Cognition, Learning Style)	☐	☐

Other significant objective tests and measurable findings.

Plan: ☐ PT Eval ☐ Referral: ☐ Other:

Staff Initials Date