HISTORY FORM

PLEASE PRINT, COMPLETE AND BRING THIS FORM FOR YOUR FIRST VISIT.

Name: _____

Address: _____

Town: _____

Home Phone Number: _____ Work: _____ Mobile:_____

Today's Date: _____ Date of Birth: _____ GP Name: _____

Date of Last GP Visit:_____ Occupation:_____

Are You Currently Working? _____ Hours Worked per week: _____

How Did You Hear About Harbour Clinic? _____

Your email address is requested for email notification of upcoming appointments. Also, you may opt-in to receiving Harbour Clinic newsletters.
Email address: _____

(Please Check) I agree to allow Mark O'Brien, PT to contact me for notification of upcoming scheduled appointments or routine correspondence:

- Yes No

I wish to receive email Newsletters and Updates on Harbour Clinic:
_____ Yes _____ No

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THIS FORM AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS.

1. What is your **primary complaint** that brings you here? Please describe your symptoms as specifically as possible.

Secondary complaint?

2. **When** did your symptoms begin? _____

3. How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known cause? (Use back of form if necessary)

4. On the lines below, place a slash mark to indicate your **functional ability** as a % of normal.
On a good day 0%_____100%

On a bad day 0%_____100%

5. Put a slash mark on the line below to rate the **INTENSITY** of your symptoms.

No pain 0% _____100% Worst pain imaginable

Put a slash mark on the line below to rate the **FREQUENCY** of your symptoms.

No pain 0% _____100% Constant pain

Put a slash mark to indicate your ENERGY LEVEL on an average day.

No energy 0% _____100% Lots of energy

6. **WHAT ARE YOUR GOALS FOR THERAPY?**

7. **PAST MEDICAL HISTORY**: Please list any/all surgeries (including cosmetic surgeries), traumas, accidents, or other conditions (and the year they occurred) that you have had throughout your life; even those you do not think have impact on your pain.

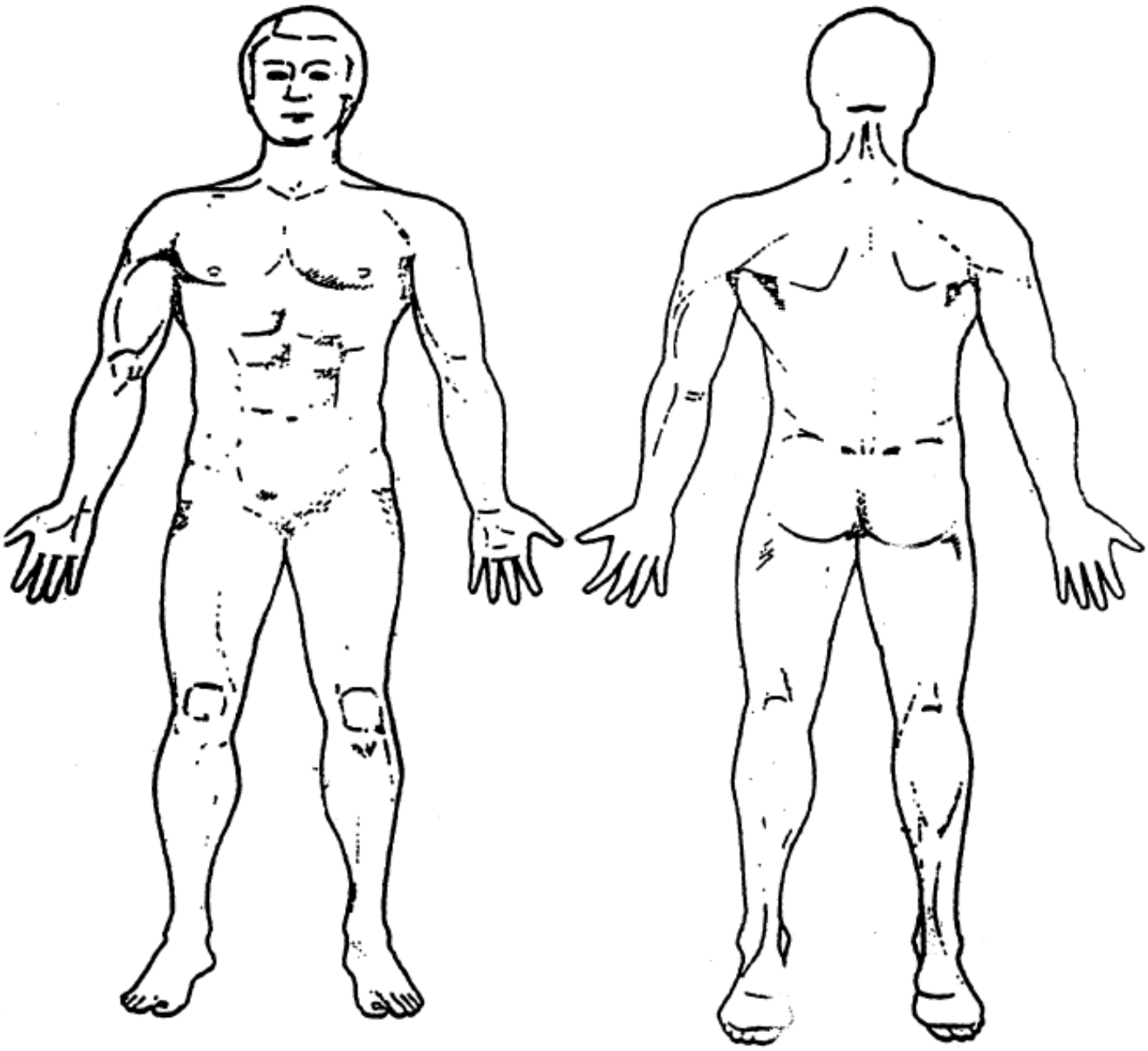
8. Have you received physical therapy for your current condition? If yes, was it helpful? Have you received any other intervention (chiropractic, massage, acupuncture, etc.) and was it helpful?

9. Are you currently taking any medication? If yes, please comment on their effectiveness.

10. Is there anything else that would be helpful for us to know?

11. Please list your Health Insurance provider.

PLEASE SHADE AREA(S) OF PAIN OR DSYFUNCTION IN THE PICTURES BELOW AND INDICATE ANY SCARS.



Please read fully before signing.
I understand that my healthcare provider may not reimburse therapy services and services rendered are not contingent on reimbursement. I agree to give 12 hours notice in the event of a session cancellation or I will be obligated to pay the full session fee.

_____ _____
Signature Date