

COMPLIMENTARY CONSULTATION WORKSHEET



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

	<u>Not Impaired</u>	<u>Impaired</u>
Cardiovascular / Pulmonary System (HR, RR, BP, Edema) _____	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary System (Integrity, Scar Formation, Color) _____	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal System (Gross Strength, ROM, Symmetry) _____	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular System (Balance, Gait, Locomotion, Transfers, Motor Function) _____	<input type="checkbox"/>	<input type="checkbox"/>
Communication System (Affect, Cognition, Learning Style) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other significant objective tests and measurable findings.		

Plan: <input type="checkbox"/> PT Eval <input type="checkbox"/> Referral: _____ <input type="checkbox"/> Other: _____	Staff Initials _____	Date _____