



**PT-OT Professionals**  
Physical-Occupational Therapy INC.

2001 7th Street (605) 716-6474  
Rapid City, SD 57701 Fax (605) 716-6484

**Thank you for choosing PT-OT Professionals Inc. The information you provide below is intended for treatment purposes only and will remain confidential.**

List your complaints in order of severity:

- 1. \_\_\_\_\_ Date of Onset: \_\_\_\_\_
- 2. \_\_\_\_\_ Date of Onset: \_\_\_\_\_
- 3. \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Please check if you have now or have had in the past any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Neck Pain                 |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Pins and Needles in Legs  |
| <input type="checkbox"/> Heart Disease/Attack         | <input type="checkbox"/> Neck Stiffness            |
| <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Pins and Needles in Arms  |
| <input type="checkbox"/> Chronic Headaches            | <input type="checkbox"/> Numbness in Hands/Fingers |
| <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Irritability              |
| <input type="checkbox"/> Nervous Disorders            | <input type="checkbox"/> Chest Pains               |
| <input type="checkbox"/> Hernia, if so, type _____    | <input type="checkbox"/> Numbness in Toes          |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Shortness of Breath       |
| <input type="checkbox"/> Respiratory Problems         | <input type="checkbox"/> Sleeping Problems         |
| <input type="checkbox"/> Metal Implants               | <input type="checkbox"/> Head feels heavy          |
| <input type="checkbox"/> Allergies, if so, list _____ | <input type="checkbox"/> Lightheaded               |
| <input type="checkbox"/> Previous Surgeries           | <input type="checkbox"/> Low Back Pain             |
| <input type="checkbox"/> Seizures                     | <input type="checkbox"/> TMJ (Jaw) Problems        |

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_