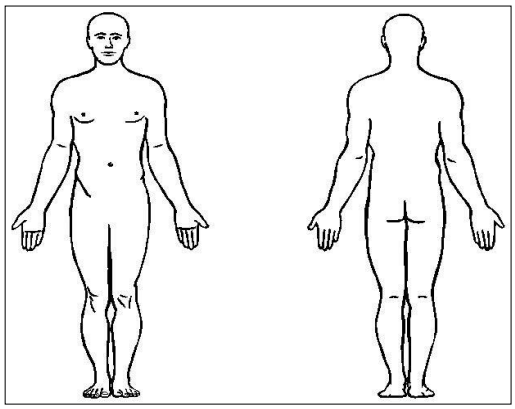
Chautauqua Physical & Occupational Therapy

Episode of Care Form

Patient Name: _____ DOB _____

CURRENTLY YOUR REASON FOR TREATMENT IS: _____

Indicate where your symptoms are on the body chart to the right.



CURRENT SYMPTOMS (circle all that apply):

PAIN NUMBNESS STIFFNESS WEAKNESS or _____

Symptoms are: (check one)
__**Constant** (all day long, nonstop)
__**Intermittent** (changes with activity, position, time of day, etc)

Condition is: (check one)
__**Acute** (*began less than 6 wks ago)*
__ **Chronic** *(began more than 6 wks ago or frequent similar episodes in the past).*

When did your symptoms begin? _____ If applicable, how many past episodes: _____
Onset of symptoms was **sudden** or **gradual.** If gradual, how long: yrs___ months____ wks____days ____

Briefly describe: _____

HAVE YOU HAD ANY DIAGNOSTIC TESTS? (Circle all that apply)
MRI X-RAY SURGERY (INCL. DATE) _____ Other: _____

Are you aware of your **DIAGNOSIS?** YES NO

Are you aware of your **PROGNOSIS?** YES NO **NEXT KNOWN PHYSICIAN'S VISIT:** _____

WEIGHT: _____ **HEIGHT**: _____ **THIS INJURY IS:** Work Related Auto Accident Other: _____

List up to 2 things that make your symptoms **better** or **worse**: (Could include, but not limited to i.e.; posture, position, rest, exercise, work tasks, household tasks, hobbies, medications, etc)

Better	Worse
1. _____	1._____
2. _____	2._____

List up to 2 personal **goals of treatment:** (for example: to reduce pain, numbness; to sleep, work, exercise without interruption, to improve range of motion, strength, balance, to resume golf, social activities, walking, reaching into cabinet, housekeeping, return to sport, etc.)

1. _____

2._____

Prior/normal Sports/Recreational/or Hobbies: _____

Prior type of Exercise and Level: _____ None Moderate Intense