Potential Physical Therapy

NAME: _____ DATE OF BIRTH (DOB): _____
GENDER: M / F AGE: _____ HEIGHT: _____ WEIGHT: _____
SSN: _____
STREET ADDRESS: _____
CITY: _____STATE: _____ ZIP: _____
PHONE Home (_____) _____
PHONE Cell (____) _____PHONE Work (_____) _____
EMAIL ADDRESS: _____
EMERGENCY CONTACT: _____ PHONE: (____) _____
PHYSICIAN: _____ FACILITY: _____ PHONE: (____) _____
NEXT DOCTOR'S VISIT: _____

HOW DID YOU HEAR ABOUT US?
_____

CHIEF COMPLAINT /BODY PART TO BE TREATED:
_____
_____

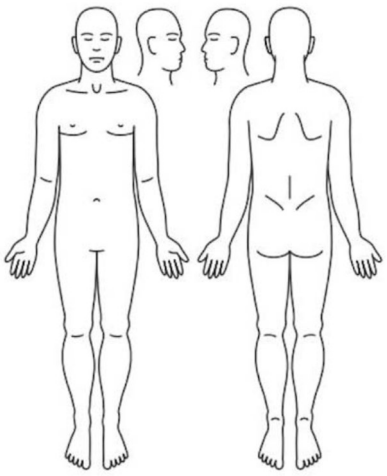
Have you had any diagnostic study for your condition?
X-ray MRI CT Scan EMG Doppler US Bone scan Blood work Other

DO YOU HAVE ANY ALLERGY? Yes / No If Yes, Specify: _____

HAVE YOU RECEIVED THERAPY/HOME HEALTH FROM A DIFFERENT PROVIDER WITHIN THE LAST 12 MONTHS?
YES **/** NO **If** YES, FACILITY: _____
_____

How would you rate your overall health? Excellent / Good / Fair / Poor

Indicate on the drawings to the right where you have pain/symptoms.



How would you describe the type of pain?
□ Sharp
□ Dull
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Other: _____

How are your symptoms changing over time?
Getting worse / Staying the same / Getting better

Does your pain wake you up at night? Yes / No

What time of the day is your pain worst? Morning / Afternoon / Evening / Night

Does your pain fluctuate with activity? Yes / No

What makes your symptoms worse? Sitting / Standing / Walking / Lifting / Bending / Lying down / squatting / Stress / Other

What makes your symptoms better? Sitting / Standing / Walking / Lifting / Bending / Lying down / squatting / Stress / Other

Are you totally ever pain free? Yes / No

How would you rate your pain/problem? (0 being no pain/problem & 10 being worst possible pain).
0 1 2 3 4 5 6 7 8 9 10

Are you pregnant? NO / YES Due date: _____

Have you had any falls in the last 12 months? Yes / No: If Yes, How many? _____

Do you have any other orthopedic problem? Yes / No
If Yes, please explain _____

List relevant surgical procedures and dates:
_____
_____
_____

Check the box if you have any of the following:

Alcoholism	Fibromyalgia	Parkinson's Disease
Anemia	Glaucoma	Polio
Angina/Chest Pain	Gout	Prosthesis
Arthritis	Headaches	Psychiatric Care
Asthma	Heart Attack	Rheumatic Fever
Cancer	Heart Disease	Rheumatoid Arthritis
Chemotherapy	Heart Murmur	Seizures
Diabetes	Herniated Disc	Shingles
Difficulty Breathing	High/Low Blood Pressure	Stroke
Drug Abuse	Kidney Problems	Tuberculosis
Elbow/Upper Arm Pain	Multiple Sclerosis	Tumors/Growths
Emphysema	Osteoporosis	Wounds
Epilepsy	Pacemaker	Ulcers

Who else have you seen for your problem?
□ Chiropractor □ Physical Therapist □ Primary Care Physician □ Neurologist □ ER Physician □ Orthopedist
□ Other: _____

How long have you had this problem, and how did it begin?
_____

What concerns you the most about your problem and what does it prevent you from doing?
_____

List all prescriptions and over-the-counter medications you are currently taking:

_____

_____

What is your goal for physical therapy:

_____

_____

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY
KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO MY MEDICAL STATUS.

Signature of Patient_____ Date: _____

Patient's medical history reviewed by Physical Therapist to determine individualized Plan of care.

Therapist signature _____Date: _____