Patient Information

Name: (last) _____ (first) _____ (middle initial) _____.

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight:_____

Address: _____ Email Address: _____

Phone number: _____ Cell Phone number: _____ Preferred contact method?_____

Emergency Contact Name: _____ Emergency Contact Number: _____

Referring Physician_____ Primary Care Physician: _____

Describe why you are seeking Physical Therapy

_____

Date this began (if chronic, please identify exacerbation date): _____

Have you had this issue in the past? (Circle) Yes No If yes, did you receive treatment? (Circle) Yes No .

What type of treatment did you receive? _____ Was it effective? ? (Circle) Yes No

History of present illness/injury

How did your condition develop? _____

Occupation history: _____ Has your work status changed? (Circle) Yes No .

Are you receiving workers compensation or in litigation? (Circle) Yes No .

Employer Name: _____Employer Phone Number:_____

Tests you have had (check all that apply or have been conducted n the last five years)

☐ Arthroscopy	☐ Doppler/Ultrasound	☐ Myelogram	☐ X-Ray
☐ Bone Scan	☐ EMG/NCV	☐ Stress Test	☐ Other _____
☐ CT Scan	☐ MRI	☐ Vestibular	☐ Other _____

Systems Review (please check (✓) all that apply to your current condition and X conditions you have had in the past)

☐ Abdominal Pain	☐ Congestive Heart Failure	☐ Hearing Issues	☐ Phlebitis/blood clots
☐ Alcohol Abuse	☐ Depression	☐ Heart Attack	☐ Pregnant
☐ Anemia	☐ Diabetes	☐ Heart disease	☐ Psychological tx
☐ Angina (chest pain)	☐ Drug abuse	☐ Heart surgery	☐ Skin disease
☐ Anxiety	☐ Epilepsy	☐ High blood pressure	☐ Stress
☐ Arthritis	☐ Fainting or dizziness	☐ Joint replacement	☐ Stoke
☐ Asthma	☐ Fibromyalgia	☐ Kidney/Liver disease	☐ TMJ
☐ Bladder changes	☐ Fractures	☐ Lung disease	☐ Tobacco use
☐ Bowel changes	☐ Frequent falls	☐ Multiple Sclerosis	☐ Tumors
☐ Cancer	☐ Gastrointestinal issues	☐ Osteoporosis	☐ Urinary Tract Infection
☐ Carpal tunnel syndrome	☐ Gout	☐ Pacemaker	☐ Unexplained weight loss
☐ Circulatory issues	☐ Headaches	☐ Parkinson's disease	☐ Vision issues

When was your last physical? _____ Do you know your average blood pressure? _____

List any surgical history (include dates) _____

List known allergies: _____

Patient name: _____ ***Date of birth:*** _____

Describe your present illness or injury

☐ Sharp	☐ Numbness	☐ Tingling	☐ Dull ache
☐ Shooting	☐ Throbbing	☐ Burning	☐ Other

☐ Constant (76 – 100%)	☐ Frequent (51-75%)	☐ Occasional (26-50%)	☐ Intermittent (24% or less)

Circle intensity of pain at rest: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Circle intensity of pain with movement: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

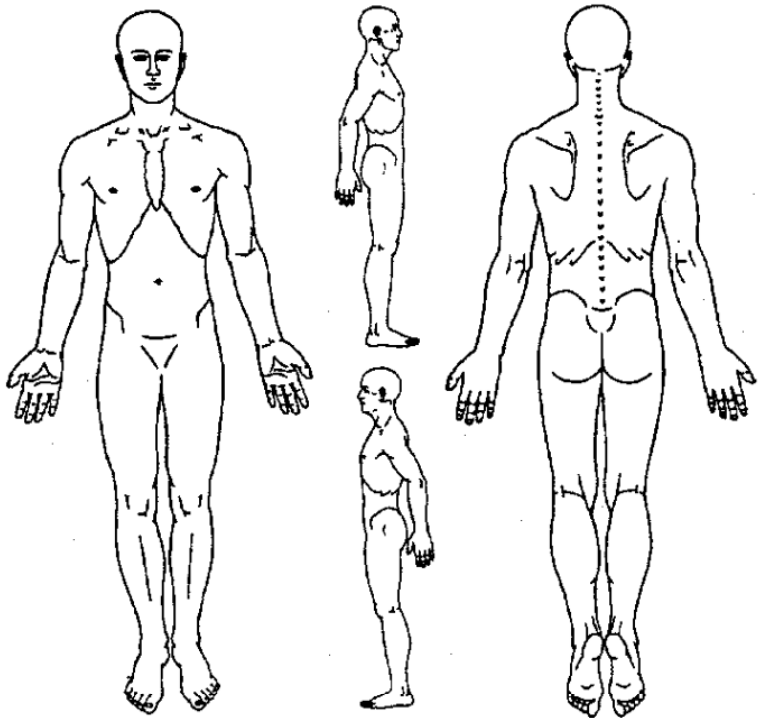
What makes it feel better _____ What makes it feel worse _____

When are your symptoms the best and worst? (Please X boxes below)

Best Time	☐ Morning	☐ Afternoon	☐ Night
Worst Time	☐ Morning	☐ Afternoon	☐ Night

Please label the diagram where you have symptoms with the following symbols:

Numbness - - - -	Pins/Needles 0000	Burning ^^^^	Aching XXXX	Stabbing ⌖⌖⌖⌖



Patient name: _____ ***Date of birth:*** _____

Current medications

Please list all medications you are currently taking, along with the dosage, frequency, and condition it is intended to treat. Please include all prescription and over-the-counter medications, along with vitamin, mineral, herbal, or other dietary supplements. If additional space is needed, please add additional information on the back of this page.

Medication	Dosage	Frequency	Condition

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____