PHYSICAL THERAPY

PATIENT INFORMATION

Where your health is our commitment. Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions, please let us know.

Name: _____ Birthdate: _____ M or F

Address: _____ City: _____

State: _____ Zip: _____ Please Circle: Married Single Minor Widowed Divorced

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact: _____Relationship: _____

Phone: _____

Rehab Information

Injury/ Complaints: _____

Date of Injury: _____ Date of Surgery: _____

Briefly describe how you were injured: _____

_____

Have you received therapy for this condition? ❑ Yes or ❑ No

If yes, when? _____ How many visits? _____

Your condition been getting? ❑ Worse ❑ Same ❑ Better Your symptoms: ❑ Constant ❑ Intermittent

Mark the number that best corresponds to your pain. *Please Circle*:

At Best: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

At Worst: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

What decreases or makes your condition better? *Check all that apply.* ❑ Bending ❑ Movement ❑ Rest ❑ Better in AM ❑ Sitting ❑ Standing ❑ Heat ❑ Ice ❑ Better as Day Goes On ❑ Rising ❑ Lying ❑ Walking ❑ Better in PM ❑ Position Change ❑ Medications

What increases or makes your condition worse? *Check all that apply.* ❑ Bending ❑ Movement ❑ Rest ❑ Worse in AM ❑ Sitting ❑ Standing ❑ Heat ❑ Ice ❑ Better As Day Goes On ❑ Rising ❑ Lying ❑ Walking ❑ Worse in PM ❑ Position Change ❑ Medications ❑ Prolonged Position ❑ Stairs ❑ Cough ❑ Sneeze ❑ Deep Breath

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Previous medical intervention. *Check all that apply.*

❑ X-RAY ❑ MRI ❑ CATSCAN ❑ INJECTIONS ❑ OTHER _____

What are your goals to be achieved by the end of therapy? _____

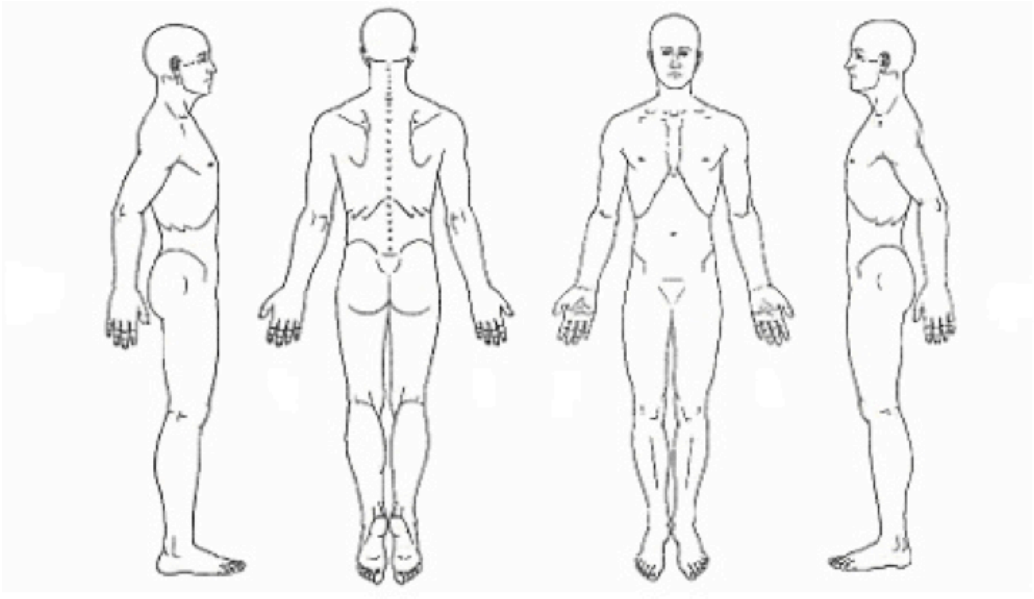
_____

Physicians Name: _____ Last Visit: _____

Have you had a blood transfusion? ❑ YES ❑ NO Nursing? ❑ YES ❑ NO Take birth control? ❑ YES ❑ NO

Draw in areas of pain on body diagrams using appropriate symbols.

Severe Pain ******* *Radiating Pain* **~~~** *Dull Ache* **###** *Moderate Pain* **OOO** *Numbness/Tingling* **XXX**



Mark if you have or have had problems with any of the following: ❑ Anemia ❑ Hepatitis ❑ Ulcer
❑ Hemophilia ❑ Arthritis/Rheumatism ❑ Hernia Repair ❑ Venereal Disease ❑ Hiv/Aids
❑ Artificial Heart Valves ❑ High Blood Pressure ❑ Artificial Joints ❑ Tuberculosis ❑ Asthma
❑ Jaw Pain ❑ Tonsilitis ❑ Back Problems ❑ Kidney Disease ❑ Tobacco Habit ❑ Bleeding ❑ Stroke
❑ Liver Disease ❑ Thyroid Problems ❑ Blood Disease ❑ Mitral Valve Prolapse ❑ Cancer ❑ Epilepsy
❑ Pacemaker ❑ Chemical Dependency ❑ Radiation Treatment ❑ Chemotherapy ❑ Skin Rash
❑ Respiratory Disease ❑ Circulatory Problems ❑ Rheumatic Fever ❑ Congenital Heart ❑ Headaches
❑ Cortisone Treatments ❑ Coughing Blood ❑ Shortness Of Breath ❑ Coughing Persistently
❑ Diabetes ❑ Fainting ❑ Glaucoma ❑ Heart Murmer ❑ Heart Problems

Allergies: _____

Current Medications: _____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

_____ _____

Signature of Patient *Date*

_____ _____

Signature of Responsible Party (if applicable) *Date*