



Name: _____ Date of Birth: _____ Date: _____

Home Phone Number: _____ Mobile Phone Number: _____ Email: _____

Billing Address: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Age: _____ Height: _____ Weight: _____

Gender: Male Female Non-Binary/Third Gender Prefer to Self-Describe Prefer Not to Say

How did you hear about us?

Doctor	Friend/Family	I've had PT here before
Google Review	Website	Other:

Tell us about your injury or symptoms:

Injury Date: _____ Physician Diagnosis: _____

How it occurred: _____

What region(s) are affected by your current symptoms?

Head/Neck	Upper Back	Shoulder	Arm	Hand/Wrist	Hip
Pelvis	Lower Back	Knee	Leg	Ankle/Foot	Other:

What kind of symptoms are you experiencing?

Tenderness	Spasm	Numbness	Tingling	Aching
Sharp	Shooting	Dull	Other:	

When are the symptoms/pain worse?

In the morning	During the day	At night	With activity
At rest	None	Come and go	Constant

When are the symptoms/pain at it best?

In the morning	During the day	At night	With activity
At rest	None	Come and go	Constant

Please indicate the intensity of pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable).

Current: _____ Best: _____ Worst: _____

If you had any testing for this issue, circle all that apply and provide the results if able.

X-Rays: Results : _____ **MRI:** Results : _____

CT Scan: Results : _____ **Other:** Results : _____

EMG/Nerve Conduction Test: Results : _____



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Have you had surgery for this issue? NO YES (Date): _____ What? _____

Have you ever had any treatment for this issue?

Medication	Beneficial?	YES	NO	Explain: _____
Injection	Beneficial?	YES	NO	Explain: _____
Physical Therapy	Beneficial?	YES	NO	Explain: _____
Occupational Therapy	Beneficial?	YES	NO	Explain: _____
Massage/Chiropractic	Beneficial?	YES	NO	Explain: _____
Other	Beneficial?	YES	NO	Explain: _____

Have you fallen within the last year? YES NO
 Do you feel unsteady when standing or walking? YES NO
 Do you worry about falling? YES NO

Please circle the conditions that you have been or are presently being treated for. This information helps your therapist develop a treatment plan that will be best for you.

- | | | |
|--|-----------------------------|-----------------------------------|
| Acquired Respiratory Distress Syndrome | Fibromyalgia | Night Pain |
| Allergies | Headaches | Numbness/Tingling in Hip/Buttocks |
| Anemia | Hearing Impairment | Osteoporosis |
| Angina | Heart Attack | Pacemaker |
| Anxiety or Panic Disorders | Heart Disease | Pain with Cough/Sneeze |
| Arthritis | Heart Palpitations | Parkinson's Disease |
| Asthma | Hepatitis, A, B, C | Peripheral Vascular Disease |
| Bleeding Disorders | Hernia | Polio |
| Bowel/Bladder Abnormalities | High Blood Pressure | Pregnancy |
| Cancer | HIV/AIDS | Recent Dizziness/Fainting |
| Chronic Obstructive Pulmonary Disease | Hyperthyroidism | Recent Fever |
| Congestive Heart Failure | hypoglycemia | Ringling in your Ears |
| Defibrillator | Hypothyroidism | Sexual Dysfunction |
| Degenerative Disc Disease | Immunosuppressant Condition | Skin Abnormalities |
| Depression | Intolerance to Cold | Smoking |
| Diabetes | Intolerance to Heat | Special Diet Guidelines |
| Dizzy or Fainting Spells | Kidney Problems | Stroke or TIA |
| Emphysema | Liver/Gallbladder Problems | Tuberculosis |
| Epilepsy or Seizer Disorder | Low Blood Pressure | Unexplained Weight Change |
| Fracture | Metal Implants | Upper Gastrointestinal Disease |
| | Multiple Sclerosis | Urine Leakage |
| | Nausea/Vomiting | Visual Impairment |



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Is your injury related to any of the following: **Auto Related**, **Work Related**, **Other Accident Related**?

Please complete the following information if Auto Related:

Insurance Company Name: _____

Claim #: _____ Date of Incident: _____

Accident State: _____ Adjuster: _____

Please complete the following information if Work Related:

What is your employment status? Full-Time Part-Time None

Please enter your employer's information: Employer's Name: _____

Phone: _____ Address: _____

What is your occupation? _____ Are you currently working? _____

Please circle all that apply to your current employment duties/responsibilities/requirements:

- | | |
|--|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Computer Work | <input type="checkbox"/> Crawling |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Heavy Lifting | <input type="checkbox"/> Pushing/Pulling |
| <input type="checkbox"/> Traveling | <input type="checkbox"/> Gripping/Pinching |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Other: _____ | |

Please complete the following information if Other Accident Related:

Insurance Company Name: _____

Claim #: _____ Date of Incident: _____

Nurse Case Manager/Adjuster: _____



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What are your goals for therapy? _____

Are there any other issues/concerns that you think we should know about that may or may not affect your ability to benefit from physical therapy? YES: _____ NO

Patient Signature: _____ Date: _____