

PHYSICAL THERAPY INFORMATION FORM

Please fill out this form prior to your initial treatment session.

1. Circle if you've had any of the following:

diabetes	varicose veins	neurological problems
rheumatic fever	circulatory problems	stroke
heart murmur	lung disease	broken bones/fractures
high blood pressure	epilepsy/seizures	kidney disease
heart disease	cancer	liver disease
migraine headaches	arthritis	metal implants
infectious disease	osteoporosis	

2. List any surgeries/hospitalizations: _____

3. List any medications you are presently on: _____

4. Are you allergic to any medications?: _____

5. Do you have a pacemaker? YES NO

6. Do you have any skin allergies? YES NO

7. Do you have any sensitivities to hot or cold? YES NO

8. In general, your lifestyle is (circle one): Inactive Average Very Active

9. Females: Is there a chance you may be pregnant at this time? YES NO

10. Are you currently working? YES NO Job Title _____

11. What are your goals for therapy? _____

12. Please add any other comments you may have: _____

13. In case of emergency, who should be notified? _____

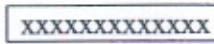
Phone number: _____

PLEASE CONTINUE ON OTHER SIDE>>>>

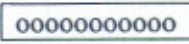
14. On the diagram, indicate where and what type of symptoms you have by shading the areas as indicated:



Pain

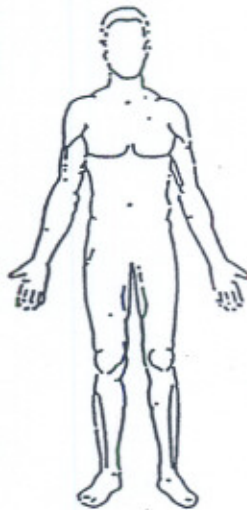


Tingling



Numbness

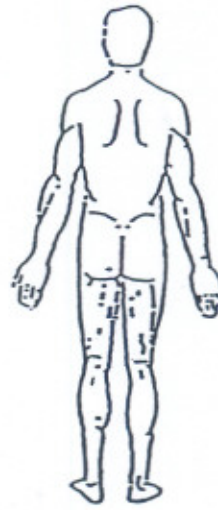
R



L

L

R



15. Pain Scale: Please circle number where pain currently is:

0 1 2 3 4 5 6 7 8 9 10
 No pain Emergency Room Pain

16. When did this problem begin? _____

17. What types of activities or postures aggravate your symptoms? _____

18. What types of activities or postures relieve your pain? _____

19. Are you involved in any legal action? YES NO

 Patient Signature

 Date

 Therapist Signature

 Date