All-Care Physical Therapy Center

Name:		**Date:**	

Directions: Please fill in all spaces, if not applicable, please put N/A.

Medical History (Please √ all that apply to you.)

_____ Pacemaker	_____ Pregnancy (C-Section? Y/N)	_____ Stroke (R or L side involved)
_____ Chest Pain (nitro? Y/N)	_____ Osteoporosis/Osteopenia	_____ Allergies to Heat/Cold (circle)
_____ High Blood Pressure	_____ Diabetes	_____ Other Allergies _____
_____ Heart Disease/Palpitation	_____ Cancer: Type: _____	_____ Asthma/Breathing Difficulties
_____ Heart Attack	_____ Kidney Problems	_____ Falls/Loss of Balance
_____ Bypass Surgery (CABG)	_____ Bowel/Bladder Abnormalities	_____ Orthopedic Surgery: Type:_____
_____ Dizziness/Fainting	_____ Liver/Gall Bladder Abnormalities	_____ Total Hip (precautions? Y/N)
_____ Seizures	_____ Skin Abnormalities	_____ Total Knee Metal Plates/screws
_____ Smoking, # of Yrs ___	_____ Hernia	_____ Rotator Cuff Repair Arthroscopic
_____ Osteoarthritis/RA	Other:	

Height: _____ft. _____ in. **Weight:** _____ lbs

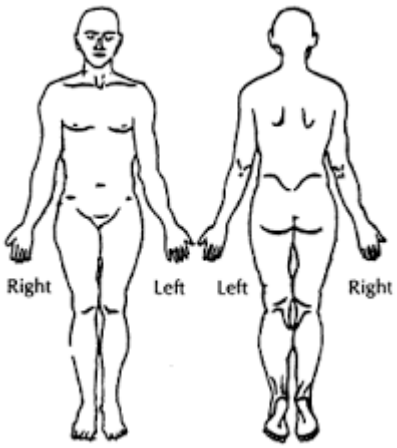
Are you presently taking any prescriptions, vitamins, supplements or over the counter medications? _____ If yes, please list including name, dosage, frequency, and route of administration. _____

_____

_____

_____

Have you received physical therapy treatment before? Y / N For the same problem? Y / N



Reason for visit: _____

Date of injury, surgery or onset of symptoms: _____

Date of next doctor's visit: _____

Mark an X on the picture where you have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain).

1 2 3 4 5 6 7 8 9 10

How often does it occur? _____

Did you get imaging studies? (Circle all that apply)

X rays MRI CT Scan Bone Scan Other _____

Dates of imaging: _____

Any additional Information we should know:

_____

_____

Employment Information

Are you presently working? _____What is your occupation? _____

Length of time with work limitations? _____ Any Worker's Comp Case or Litigation? Y /N