



**PHYSICAL THERAPY AND SPORTS MEDICINE**

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**SINCE THE ONSET OF YOUR CURRENT SYMPTOMS, HAVE YOU HAD?**

Bowel or bladder dysfunctions	YES	NO	Fever/Chills	YES	NO
Numbness in genital or anal area	YES	NO	Numbness	YES	NO
Dizziness or fainting	YES	NO	Weakness	YES	NO
Unexplained weight change	YES	NO	Night pain/sweats	YES	NO
Do you smoke cigarettes or use chewing tobacco?	YES	NO			
Do you drink coffee or caffeinated beverages?	YES	NO			
Do you drink alcohol?	YES	NO			

**1. PLEASE MARK YOUR PAIN LEVEL**

0 \_\_\_\_\_ 10  
 No Pain \_\_\_\_\_ Worst pain Imaginable

**2. PLEASE MARK YOUR FUNCTIONAL EVERY DAY ACTIVITIES LEVEL**

0% \_\_\_\_\_ 100%  
 Unable \_\_\_\_\_ All Normal Activities

**3. PLEASE MARK YOUR FUNCTIONAL WORK LEVEL**

0% \_\_\_\_\_ 100% **Occupation:** \_\_\_\_\_  
 Unable \_\_\_\_\_ All Normal Activities

**4. PLEASE MARK YOUR RECREATIONAL / SPORT ACTIVITY LEVEL**

0% \_\_\_\_\_ 100% **Activity:** \_\_\_\_\_  
 Unable \_\_\_\_\_ All Normal Activities



**PHYSICAL THERAPY & SPORTS MEDICINE**

**IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR INSURANCE BENEFITS**

DATE YOU RETURN TO PHYSICIAN? \_\_\_\_\_ HAVE YOU HAD PHYSICAL THERAPY IN 2015 \_\_\_\_\_

DATE OF INJURY/SURGERY? \_\_\_\_\_ CLAIM # \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Physical Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Are you married? Yes No Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact : \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

FOR MEDICARE: DATE OF RETIREMENT: \_\_\_\_\_ DATE OF SPOUSE RETIREMENT: \_\_\_\_\_

**MEDICAL HISTORY** Are you currently under the care of any of the following?

Medical Doctor Osteopath Naturopath Psychiatrist Physical Therapist Chiropractor Neurologist Other? \_\_\_\_\_

**Have you or any immediate family member been diagnosed with any of the following conditions?**

<u>YOU</u>	<u>FAMILY</u>	<u>YOU</u>	<u>FAMILY</u>	<u>YOU</u>	<u>FAMILY</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies \_\_\_\_\_

Any Surgeries /Injuries?/ Hospitalizations? \_\_\_\_\_

List any Prescriptions or over the counter medications you are currently taking: \_\_\_\_\_