STEAMBOAT PHYSICAL THERAPY

Patient Name _____ Age _____ Height _____ Weight _____

Occupation _____ Currently Working? ☐ Y ☐ N

Referring Physician _____ Primary Physician _____

Last appointment with Physician _____ Next appointment _____

Medical History

Do you currently or have you ever had any of the following? Please check all that apply.

☐ Allergies	☐ Dizzy Spells	☐ MRSA
☐ Anemia	☐ Emphysema/Bronchitis	☐ Multiple Sclerosis
☐ Anxiety	☐ Fibromyalgia	☐ Muscular Disease
☐ Arthritis	☐ Fractures	☐ Osteoporosis
☐ Asthma	☐ Gallbladder Problems	☐ Parkinson's
☐ Autoimmune Disorder	☐ Headaches	☐ Rheumatoid Arthritis
☐ Cancer (Mo/Yr ___/_____)	☐ Hearing Impairment	☐ Seizures
☐ Cardiac Conditions	☐ Hepatitis	☐ Smoking
☐ Cardiac Pacemaker	☐ High Cholesterol	☐ Speech Problems
☐ Chemical Dependency	☐ High/Low Blood Pressure	☐ Strokes
☐ Circulation Problems	☐ HIV/AIDS	☐ Thyroid Disease
☐ Currently Pregnant	☐ Incontinence/Bowel/Bladder	☐ Tuberculosis
☐ Depression	☐ Kidney Problems	☐ Vision Problems
☐ Diabetes (Mo/Yr ___/_____)	☐ Metal Implants	☐ Other

Any falls in the last year? ☐ Y ☐ N If yes, any injuries with the fall(s)? ☐ Y ☐ N ☐ N/A

Any recent weight loss or gain? ☐ Y ☐ N Any hospitalization in the last year? ☐ Y ☐ N

Current Issue For Needing Physical Therapy

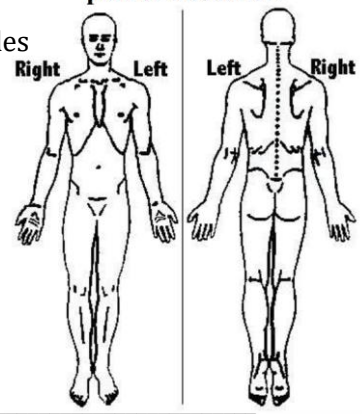
Start Date of issue or injury _____ How did it occur? _____

Have you had any of the following tests for your current problem? ☐ X-ray ☐ MRI ☐ CAT ☐ EMG ☐ None

What **kind** of pain are you having (check all that apply)?

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stiff ☐ Numb ☐ Throbbing ☐ Pins and Needles

Please draw where you have pain or discomfort



How often are you having your pain?

☐ Constantly ☐ Periodically ☐ With activity ☐ With inactivity

If 0 is no pain and 10 is the worst pain imaginable, what is the:

Least pain you have had since the injury 0 1 2 3 4 5 6 7 8 9 10

Average/typical pain you have had since the injury 0 1 2 3 4 5 6 7 8 9 10

Worst pain you have had since the injury 0 1 2 3 4 5 6 7 8 9 10

What do you have difficulty doing due to your injury? _____

What are your goals for physical therapy? _____

Authorization for Treatment: I authorize the physical therapist of Steamboat Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary based on the findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____