Revitalize Movement
PHYSICAL THERAPY

Patient Information:

Name_____

Date of Birth:_____Date of Service:_____

Address_____ City_____

State_____ Zip code_____

Phone number_____ E-mail_____

Emergency Information/Nearest Relative

Name _____

Relationship _____

Address _____City _____

State _____Zip Code _____

Home Phone_____Work_____Cell_____

From whom did you hear about us? _____

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Briefly tell me why you are here for physical therapy. _____

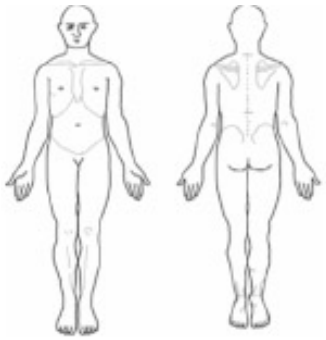
_____

_____

History of current condition. _____

_____

Please indicate where you have pain or abnormal sensation on body chart: shaded=pain, +++=numbness or tingling



When did your symptoms begin?_____

Onset of symptoms was ⎯ Gradual ⎯ Sudden?

Since date of onset, are symptoms generally same, ⎯ Better ⎯ Worse?

Please describe your relevant symptoms: ⎯ Constant ⎯ Comes and Goes

Worse in the ⎯ Morning ⎯ Afternoon ⎯ Evening q Better or worse with movement

Worse with ⎯ Sitting ⎯ Standing ⎯ Worse with changing positions or prolonged positions

⎯ Worse when bearing down for toileting

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Disturbs my sleep _ Yes _ No

Since the onset of your current symptoms have you had any of the following:

_ Unexplained muscle weakness _ Night pain _ Bowel or bladder changes

_ Hearing or vision problems _ Loss of consciousness _ Fever _ Chills _ Sweats

_ Numbness _ Tingling _ Unexplained weight change _ Dizziness/fainting

_ Unexplained fatigue

Are you taking any medications? _ Yes _ No

_____

_____

Who has treated you for this problem?

_____

_____

Do you drink caffeinated beverages? _ Yes _ No If yes, #/day? _____

Do you smoke? _ Yes _ No If yes, #/day? __ _____

Do you drink alcohol? _ Yes _ No If yes, #/week? _____

Have you ever had any of the following conditions or diagnoses? _ Cancer _ HBP _ Diabetes

_ Heart Disease _ Chest Pain/Angina _ Stroke _ Arthritis _ Polio _ Emphysema

Any special tests that have been performed, the body part tested, and the results: (ie: X-ray, MRI, Cat Scan)

_____

_____

_____

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Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

What has had a positive effect?

What has had a negative effect?

Have you been advised to have any surgery that has not been done?

Please list all previous injuries, accidents, and any other pertinent medical information:

Please list all medical conditions and/or health concerns:

Please list all current medications:

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Please list all allergies:

_____

_____

Any previous surgeries? (please note year)

_____

_____

_____

_____

Do you now have or have you had any of these symptoms in the past year?

_ Change in bowel movements _ Persistent joint pain _ Irritable bowel

_ Blood in bowel/urine _ Hot flashes _ Vertigo or dizziness _ Persistent nose bleeds

_ Difficulty concentrating _ Learning disabilities _ Tiredness/fatigue _ Muscle spasms

_ Fainting spells _ Eating disorder/difficulty _ Difficulty Sleeping _ Other

_____

_____

Any history of:

_ Head or spinal injuries _ Recurrent headaches _ Meningitis

_ Stomach ulcers _ Heartburn/indigestion _ Shortness of breath _ Anemia _ Asthma

_ Bladder infection _ Heart Problems _ Depression _ Other

_____

_____

FOR WOMEN ONLY: Please list number of:

Pregnancies_____ Children _____ Date of last pelvic exam _____

Date of last pap smear test:_____ ⎯ Negative or ⎯ positive

Please check all that apply:

⎯ Menstrual cycle irregular ⎯ Pass blood clots ⎯ Pain and cramping during period

⎯ Pain with intercourse ⎯ Take birth control? How long? _____

Any other information about pregnancies, complications with delivery, menstrual problems?

_____

_____

_____