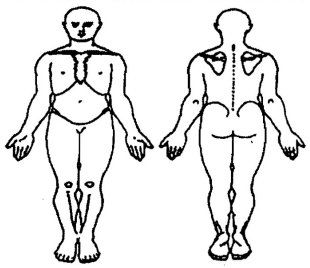
PT² *Physical & Sports Therapy with a Personal Touch*

Medical History

Name:
Age:____ Height:_____ Weight:_____ M / F
Date of Onset/Injury:
Date of Surgery:
Occupation:
Activities Done At Work:
(Example:lifting,sitting,standing,computer,etc.)



Please mark the area(s) of concern

Rate your pain: (Example: 1=Minimal through 10=SEVERE)
Pain at it's WORST: (1 2 3 4 5 6 7 8 9 10) / Pain at it's BEST: (1 2 3 4 5 6 7 8 9 10)

Type of pain: Sharp / Burning / Aching / Tingling / Numbness / Other: _____

Do you have or have you had any of the following:				
Diabetes	Yes / No		Metal Implants	Yes / No
High Blood Pressure	Yes / No		Pregnant (Presently)	Yes / No
Heart Disease/Attack	Yes / No		Headaches	Yes / No
Pacemaker	Yes / No		History of Smoking	Yes / No
Stroke	Yes / No		Seizures	Yes / No
Cancer	Yes / No		Hernia	Yes / No
Kidney Problems	Yes / No		Previous Surgeries	Yes / No

If you answered Yes to any items above, please explain as necessary:_____

_____

Fitness Goals: Current:_____
6 Months:_____
12 months:_____

Have you received any of the following this calendar year?:
Physical/Occupational Therapy, Chiropractic / Acupuncture Yes / No

If Yes, which type of treatment: _____ Number of Sessions:_____

Was your treatment for the present injury? If different, please explain:

_____

Excluding the previous question, have you received Physical Therapy in the past 5 years?
Yes / No If Yes, explain:_____

Current Medications: _____

Anything else you would like to ask your Physical Therapist? _____

Whom may we thank for referring you to us? _____

Name of your Family/Primary Care Physician: _____

Patient Signature: _____ Date: _____

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