PTM PHYSICAL THERAPY SARATOGA

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Name:_____ **Date:**_____

Age:_____**Occupation:**_____**Work Status: FT PT Retired Not Working**

Primary Care Physician:_____

RECENT x-ray, MRI, or other tests:_____**Surgery:**_____

How did you hear about us?_____

Please answer the following questions as fully as possible:

Date symptoms began?_____**What was the cause of your current problem?**_____

_____

Have you had this before? Y N What helped you?_____

What are you doing to help yourself now?_____

Did the problem come on immediately or gradually?_____

How has your problem changed over the last 14 days?_____

What eases your symptoms?_____

What aggravates your symptoms?_____

How does it change over the course of the day?_____

Can you sleep through the night and how?_____

Please rate the severity of your pain
0 (no pain) ----- 10 (worst)

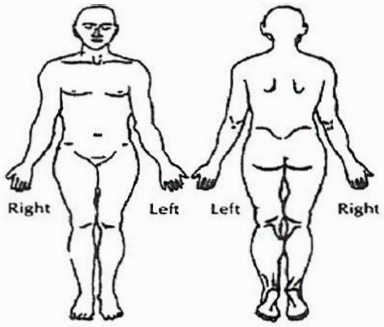
Your best:_____**/10**

Your worst:_____**/10**

What percentage of your normal functional ability are you at now?

_____

Please draw areas of symptoms on diagram



What are your functional goals?_____

Do you normally exercise and how?_____

What activities are limited by this problem?_____

PLEASE TURN OVER

Personal Medical History

Do you have any previous history of *(check all that apply)*:

Past	Present		Past	Present	
❑	❑	Cancer. What kind_____.	❑	❑	Depression
❑	❑	Heart Problems/ Pacemaker	❑	❑	Hepatitis
❑	❑	High Blood Pressure	❑	❑	Tuberculosis
❑	❑	High Cholesterol	❑	❑	Stroke/ TIA
❑	❑	Circulation Problems	❑	❑	Kidney Disease
❑	❑	Asthma	❑	❑	Anemia
❑	❑	Emphysema/ Bronchitis	❑	❑	Epilepsy
❑	❑	Chemical Dependency (ie. Alcoholism)	❑	❑	Osteoporosis/ Osteopenia
❑	❑	Smoking	❑	❑	Allergies
❑	❑	Thyroid Problems	❑	❑	Pregnancy
❑	❑	Diabetes	❑	❑	Heartburn/Esophageal reflux
❑	❑	Multiple Sclerosis	❑	❑	Chicken pox/Shingles/Herpes
❑	❑	Rheumatoid Arthritis	❑	❑	Bowel or bladder dysfunction
❑	❑	Other arthritic conditions	❑	❑	Current Infection?
❑	❑	Metal Implants			Type:_____

Other (ie. Past surgeries):_____

Hospitalizations within the last year:_____

Medications and Vitamins:_____

Have you recently noted any of the following:

Yes	No	Weight loss/gain	Yes	No	Shooting pain in arms and/or legs
Yes	No	Nausea/vomiting	Yes	No	Persistent cough
Yes	No	Fatigue	Yes	No	Changes or blood in stool
Yes	No	Weakness	Yes	No	Dizziness
Yes	No	Fever/chills/sweats	Yes	No	Headaches
Yes	No	Numbness/tingling	Yes	No	Blurred vision

Yes No Has your physician discussed your condition with you?

I have also read and agree to the terms stated in the clinic policy sheet.

_____ _____

Signature **Date**

_____ _____

Printed Name **Relationship**