PTX PHYSICAL THERAPY - SURGERY

Full Name: _____ Phone: _____

D.O.B:_____ Gender: ▢F ▢M ▢Other Insurance Holders Name and D.O.B:

Email:_____

Surgeon:_____ Emergency Contact:
Phone:

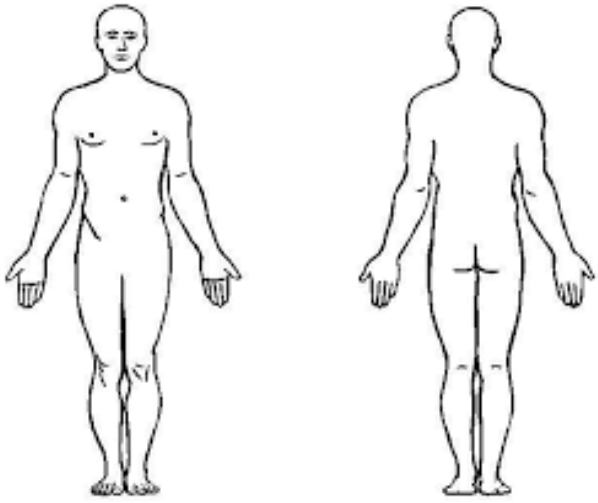
Primary Physician:_____

Type of surgery: **Surgery date:**

What symptoms are you experiencing:

▢ swelling/stiffness ▢ weakness ▢ fatigue
▢ loss of motion ▢ numbness ▢ tingling
▢ loss of balance/coordination ▢ ache/pain

On the body diagram, please indicate where your symptoms are located ---------->



Indicate on the line below, how you would rate your pain using all three letters C, B and W:

C = currently **B** = at its best **W** = at its worst

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0 1 2 3 4 5 6 7 8 9 10

0 is experiencing no symptoms at all

10 is experiencing the worst severity of symptoms

What makes symptoms better? **What makes symptoms worse?**

Do these symptoms affect your stress level, comfort or mood? ▢YES ▢ NO

Have you felt any of the following this past week, including today?

▢sad ▢hopeless ▢lack of energy ▢loss of interest in usual activities ▢none

What tests have you had for this issue?

▢ X-Ray ▢ Cat Scan ▢ MRI ▢ Myelogram ▢ Bone Scan ▢Other:

What treatment have you had for this issue?

▢Physical Therapy ▢Chiropractic ▢Nothing ▢Other--please specify:

What is your occupation and status? _____

▢ Full-Time ▢ Part -Time ▢ Not Working ▢ Retired ▢ Medical Restrictions ▢ Medical Leave

Please check all of the medical conditions you HAVE or HAVE HAD:

___Arthritis
___Pace Maker
___Chest Pain
___Stroke
___Diabetes
___High Blood Pressure
___Cancer
___Shortness of Breath
___Panic Attacks
___Fatigue
___Heart Disease
___Lung Disease
___Thyroid Disease
___Stomach Disorder
___Fibromyalgia
___Osteoporosis
___Unexplained Weight Loss
___Long Term Steroid Use
___Difficulty Sleeping
___Change in Appetite
___Fever (only currently)
___Nausea/Vomiting
___Other, Explain:

Please check all of the following items that CURRENTLY or PREVIOUSLY applied to you:

___Hearing Issues
___Visual Issues
___Learning Issues
___Bladder or Bowel issues
___Pregnant
___Substance Abuse
___Smoke, ppd___
___I have had a fall in the past 12 months that resulted in an injury
___I have had 2 or more falls in the past 12 months in which I was injured

How many hours of sleep do you get? _____ How much water do you drink a day? _____

How many days per week do you exercise?_____ What type of exercise do you do?_____

Please list all allergies:

Please list all scars & surgeries:

Please list all medications, vitamins and/or supplements you are currently taking:

List previous and current Joint/Muscle/Bone Injuries/Pain:

I have read and understand the following pages: Privacy Policy & PTX PHYSICAL THERAPY FINANCIAL, RESERVATION, and NO SHOW POLICY and agree to be bound by its terms.

---Signature_____Relationship to Patient_____
(or Parent/Legal Guardian)

---Printed Name_____ Date_____