PTX PHYSICAL THERAPY

NON-SURGICAL

Full Name: _____ Phone:_____

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

Email:

Referring Physician:_____ Emergency Contact:
Phone:

Primary Physician:_____

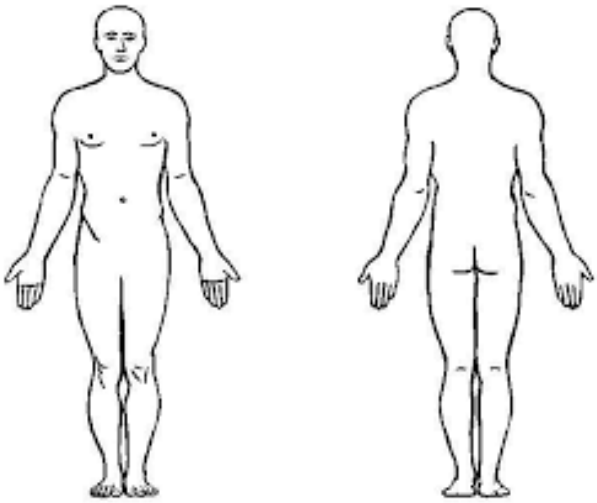
What is your complaint:

When did the complaint occur:

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 complaint?

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

\What treatment have you had for this complaint?

▢Physical Therapy ▢Chiropractic ▢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_____