Physical Therapy Associates of Schenectady, P.C.

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Name: _____ Date: _____ Primary Care Physician: _____

Have you **RECENTLY** noted any of the following (check all that apply)?

( ) changes in bowel or bladder function
( ) nausea/vomiting
( ) dizziness/lightheadedness
( ) difficulty maintaining balance while walking
( ) weight loss/gain
( ) shortness of breath
( ) headaches
( ) changes in appetite
( ) fever/chills/sweats
( ) pain at night
( ) weakness/fatigue
( ) difficulty swallowing

Have you **EVER** been diagnosed with any of the following conditions (check all that apply)?

( ) cancer (type) _____
( ) heart disease
( ) high blood pressure
( ) asthma
( ) pacemaker inserted
( ) chemical dependency (i.e., alcoholism)
( ) rheumatoid arthritis
( ) stroke
( ) depression
( ) anemia
( ) lung problems
( ) Parkinson's disease
( ) diabetes
( ) high cholesterol
( ) kidney/liver problems
( ) stomach ulcers
( ) osteoporosis
( ) other _____
( ) circulation problems
( ) other arthritic conditions
( ) blood clots
( ) epilepsy
( ) thyroid problems

***********PLEASE LIST ALL CURRENT MEDICATIONS ON THE BACK OF THIS FORM, OR PROVIDE A COPY **************

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO (circle)

Allergies: _____ **Are you latex sensitive? YES NO (circle)**

Have you fallen in the past year? Yes No (circle)

Do you smoke? Yes No _____ **pack/day** **Height** _____ **Weight** _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO (circle)**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1._____ 2._____ 3._____

Pain at LOWEST: Rate your lowest pain level in the past week.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10

Worst pain

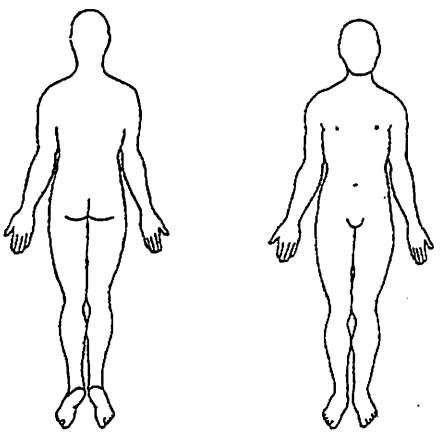
Pain at WORST: Rate your highest pain level in past week.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Body Chart:

Please mark the location of your pain and type of pain on the chart



Key:
X Sharp stabbing pain
O Dull achy pain
.... Numb/tingling
/// Throbbing
=== Burning

List 1(one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. (Circle number below)

_____ (ex. stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

What is your goal for therapy at this time? _____

Patient Signature _____ **Date:** _____

(for office use only) PT initials _____ **Date** _____

CURRENT MEDICATION LIST (DOSAGE AND FREQUENCY):

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