Hands on Therapy - The Personal Touch

Name

Age Date of Birth

Lewisboro Physical Therapy, PC
Medical History Form and Questionnaire

Please answer all questions as thoroughly as possible. All information will be kept confidential.

What is the primary problem (s) that you would like your physical therapist to address?

How long have you had the problem (s)?

What activities/ movements increase your pain?

What things help decrease your pain?

What is your occupation?

After printing this information, on the body chart below, please indicate with an "X" where your pain (s) or problems (s) are located.

On a scale of 1 to 10 click on which best describes your pain?

What activities/sports do you engage in?

What do you hope to accomplish or gain from physical therapy?

MEDICAL HISTORY - Please check all conditions that you have had or currently have and explain briefly below.

Aids/HIV	Emphysema	Liver Disease
Allergies	Fainting	Lyme Disease
Anemia	Fractures	Motor Vehicle Accident
Arthritis	Heart Disease	Neuromuscular Disorder
Asthma	Heart Attack	Psychiatric Treatment
Back/Neck Trouble	Heart Murmur	Seizures/Convulsions
Bleeding Disorders	Hepatitis	Shortness of Breath
Cancer	Herpes	Stomach Ulcers
Chest Pain	High Blood Pressure	Stroke
Diabetes	Jaundice	Swelling of Hands/Feet
Drug Abuse	Joint Replacement	Thyroid Disease
		Tuberculosis

Medications (please list)

Operations, Surgeries or Serious Injuries, Fractures, Strains or Dislocations (please list)

Are there any personal circumstances that may affect your physical therapy?

Please check any of the following that you may have or wear:

Glasses	Contacts	Dentures	Pacemaker	Metal Foreign Object Implant

Please check if you are allergic to any of the following:

Latex	Rubber	Tape	Lotions
Bees	Strawberries	Shellfish	Cortisone

Are you pregnant or trying to become pregnant? Yes No

Have you had any significant weight gain or loss in the past year? Yes No

Aside from your primary care or referring physician, are you under the care of any other medical/health care provider or physician? If yes, for what condition (s)? Please provide name (s) and phone number (s).

Emergency contact name and number

To the best of my knowledge, the information provided herein is correct.

SIGNATURE

DATE