Belmont Shore
PHYSICAL THERAPY

_____ **Age:** _____ **DOB:** _____ **Sex: M □ F □**

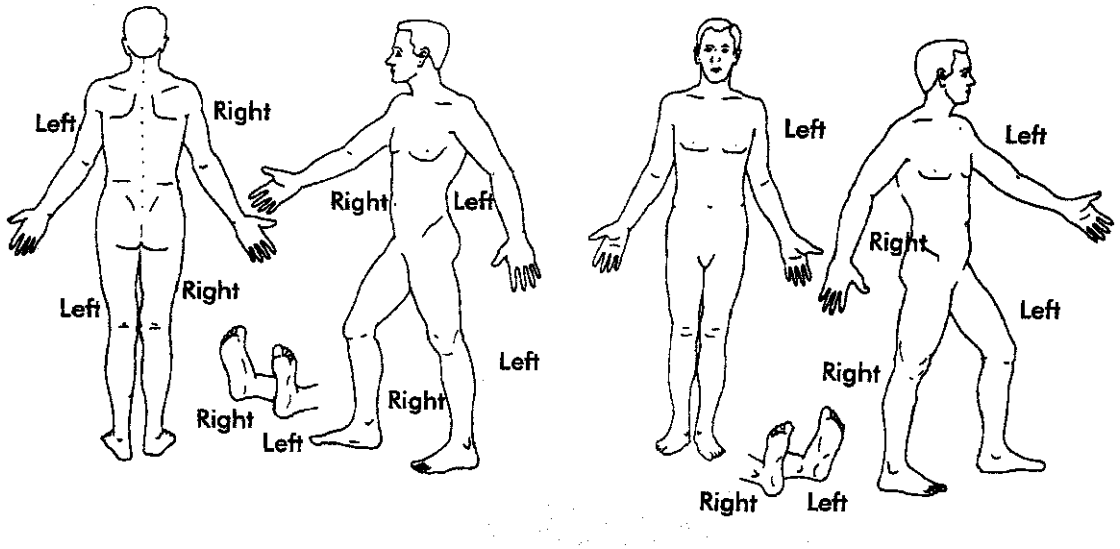
E-mail: _____ **Phone:** _____

Diagnosis/Injury: _____

Date of injury or onset of complaint(s)? _____

Chief Complaint: _____

Have you received physical therapy treatment this calendar year for the same injury? Yes □ No □
Do you have any pain? Yes □ No □ if yes, please mark the areas on the drawing below.



How do you describe your pain? (Circle all that apply)

-Throbbing -Sharp -Burning -Shooting -Nagging -Cramping -Numbness/Tingling -Dull ache –Pressure

On the following scale of 0-10, how would you rate your pain?

At Rest:

(None) 0 — 5 — 10 (Worse)

With Activity:

(None) 0 — 5 — 10 (Worse)

Is pain constant or intermittent? _____

What makes your pain increase? _____

_____

What, if anything, eases your pain? _____

_____

Do you have any metal or any other implants in your body? Yes □ No □ If yes, where?

_____

Do you smoke? **Yes□ No□ If yes how often? _____**
Do you consume alcohol? **Yes□ No□ If yes how often? _____**
Are you pregnant? **Yes□ No□ N/A□**

Medical History (check all that apply)

□ Allergies: _____
□ Arthritis
□ Asthma
□ Cancer
□ Depression
□ Diabetes
□ Heart disease
□ Head injury
□ High Blood Pressure
□ Hernia
□ HIV
□ Osteoporosis/Osteopenia
□ Seizures
□ Stroke
□ Multiple sclerosis
□ Parkinson's disease
□ Rheumatoid Arthritis
Other: _____

Are you having any of these symptoms? (Check all that apply)

□ Chest pain
□ Loss of Balance
□ Difficulty Sleeping
□ Headaches
□ Pain at Night
□ Visual Problems
□ Weakness
□ Coordination Problems

Current Medications: _____

Surgical History (Recent Dates):_____

_____

What was your exercise program prior to your injury? _____

_____

What are your goals for physical therapy?

_____

How did you hear about our practice? _____

I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Patient Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____