Kate Schwartz Physical Therapy, LLC Patient Record Form and Agreement

Name:_____Date of Birth:_____Today's Date:_____

Height:_____ Weight:_____Age:_____ R /L Handed?_____

Current Medications, Vitamins/Supplements, with dosages:_____

_____

How and When did your present pain or injury begin?_____

_____

Have you ever had anything like this before? Yes / No. Explain:_____

Where is your pain/symptoms:_____

Describe your current symptoms:_____

How does it interfere with your everyday life:_____

What increases your pain:_____

What decreases your pain:_____

Are your symptoms improving or worsening?_____Are they intermittent or constant?_____

What activities impact your symptoms?_____

Rate today's pain from Best (0) to worst (10) . Best:_____Worst: _____

Is your pain worse at certain times of the day? If so when:_____

Are there any restrictions set by your doctor? (Explain)_____

What is your occupation:_____

Are you currently working? Full time___ , Part time___, Unemployed___, Disability ___, Retired___,

Modified duty___. Out of work Date:_____ Days missed because of injury?_____ How does your problem

Interfere with work:_____

List the maximum amount of time you can tolerate the following activities before you need to change position:

Sitting :_____ Walking:_____ Driving:_____ As a passenger:_____

List any surgeries and dates:_____

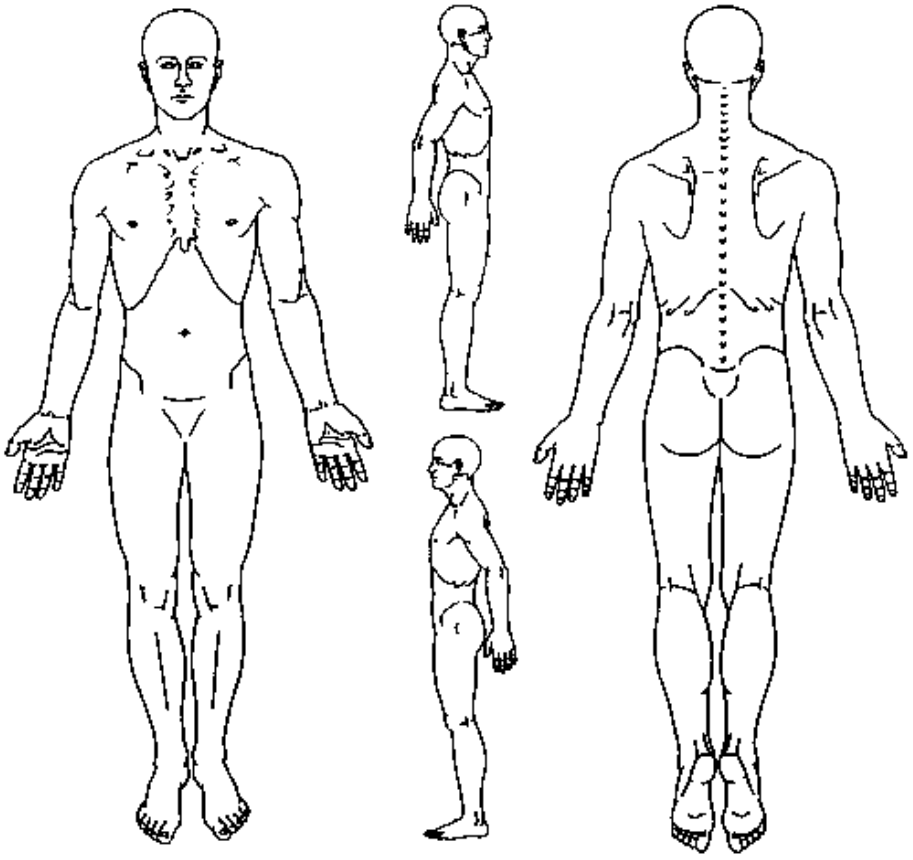
Have you previously had PT? If so, when_____

Chiropractic?_____ Occupational Therapy?_____Speech?_____When?_____

Any X-rays, MRI's, CT Scan, EMG, etc? (Dates/results)_____

PLEASE INDICATE ON THE DRAWING BELOW THE LOCATION OF YOUR SYMPTOMS

P – Pain N – Numbness T- Tingling B – Burning A - Achiness



Please check as many of the following health problems that you now have or have had:

Anemia or Blood Disease	___	Stomach/Intestinal Trouble	___	Smoker (Y/N)	_____
Heart Trouble/Murmur	___	Liver/Gallbladder Disease	___	How much day	_____
High Blood Pressure	___	Hernia	___	How long (yrs)	_____
Chest Pain/Angina	___	Diabetes/Thyroid Disease	___		
Shortness of Breath	___	Sugar/Protein in Urine	___		
Lung Disease	___	Kidney/Bladder Trouble	___	Do you drink Alcohol?	__
Allergy/Hay Fever/Asthma	___	Headaches/Migraine	___	Beer/Wine?	_____
Eye Trouble	___	Dizziness/Fainting	___	How much day/wk?	____
Deafness/Ear Trouble	___	Nervousness/Mental Illness	___		
Major Illness	___	Paralysis/Nerve Disease	___	Do you exercise regularly	
Varicose Veins/Leg Sores	___	Broken Bones	___	(at least 3 times a week)	
Cancer/Tumor/Cyst	___	Joint or Back Injury	___	YES NO	
Bone/Joint Disease	___	Arthritis/Bursitis/Ganglion	___	Doing what?	_____
Back/Disc problems	___	Recent Weight Loss/Gain	___		
Amputation Foot/Leg/Arm	___	Loss of Sight	___	Are you pregnant now?	__
Multiple Sclerosis	___	Cerebral Palsy	___	Ages of children	_____
Head Injury	___	Parkinson's Disease	___	(if any)	
Seizures/Epilepsy	___	Stroke	___		
Chronic Osteomylitis	___	Tuberculosis	___		
Phlebitis	___	Hardening of Blood Vessels	___		
Pacemaker	___	Osteoporosis	___		
Fibromyalgia	___	Anxiety/Depression	___		

Describe your major medical problems: _____

_____