



**Welcome to a better place
for physical therapy**

PATIENT'S NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET APT #

CITY: _____ STATE: _____ ZIP: _____ PHONE #: _____ - _____ - _____

SECONDARY #: _____ - _____ - _____ E-MAIL: _____

DATE OF BIRTH: ___/___/___ AGE: _____ HEIGHT/WEIGHT: _____ MARITAL STATUS: M S W D

EMERGENCY CONTACT: _____
NAME PHONE RELATION

PRIMARY CARE DOCTOR: _____
NAME CITY/STATE (IF OUT-OF-STATE)

SPECIALIST: _____
NAME CITY/STATE (IF OUT-OF-STATE)

HOW DID YOU HEAR ABOUT US? _____

PREVIOUS/CURRENT JOB TITLE: _____

DO YOU HAVE DISCOMFORT, SHORTNESS OF BREATH, OR PAIN WITH EXERCISE? YES NO

IF "YES", PLEASE DESCRIBE: _____

WHAT IS YOUR PRIMARY ISSUE/PROBLEM THAT BRINGS YOU IN TODAY? _____

SECONDARY PROBLEM(S) ? _____

FALL HISTORY -

- Injury is the result of a fall in the past year. 2 or more falls in the last year Are you at risk of falling?

Please rate your pain in the last 24 - 72 hours on a scale of 0-10 where "0" is no pain and "10" is the worst possible pain.

At worst:		At best:		At present:	
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Patient Goals - Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	Rate Current Difficulty 0-10 0 = unable to perform, 10 = perform at same level prior to injury

Other Goals:
