



STEAMBOAT PHYSICAL THERAPY

Patient Name _____ Age _____ Height _____ Weight _____

Occupation _____ Currently Working? Y N

Referring Physician _____ Primary Physician _____

Last appointment with Physician _____ Next appointment _____

Medical History

Do you currently or have you ever had any of the following? Please check all that apply.

Allergies	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	MRSA	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Emphysema/Bronchitis	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Muscular Disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>
Autoimmune Disorder	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Rheum. Arthritis	<input type="checkbox"/>
Cancer (Mo/Yr ___/___)	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Cardiac Conditions	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Smoking	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	Strokes	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	Incontinence/Bowel/Bladder	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>
Diabetes (___/___)	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	Other _____	

Any falls in the last year? Y N If yes, any injuries with the fall(s)? Y N N/A

Any recent weight loss or gain? Y N Any hospitalization in the last year? Y N

Current Injury

Date of Current Injury _____ How did the injury occur? _____

Have you had any of the following tests following your injury? X-ray MRI CAT EMG None

What **kind** of pain are you having? (check all that apply)

Sharp Dull Achy Burning Stiff Numb Throbbing Pins and Needles

How often are you having your pain? (check all that apply)

Constantly Periodically With activity With inactivity

If 0 is no pain and 10 is the worst pain imaginable, what is the:

Least pain you have had since the injury 0 1 2 3 4 5 6 7 8 9 10

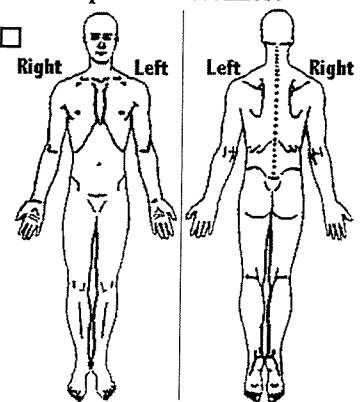
Average/typical pain you have had since the injury 0 1 2 3 4 5 6 7 8 9 10

Worst pain you have had since the injury 0 1 2 3 4 5 6 7 8 9 10

What do you have difficulty doing due to your injury? _____

What are your goals for physical therapy? _____

Please draw where you have pain or discomfort



Authorization for Treatment: I authorize the physical therapist of Steamboat Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary based on the findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____