R.A.

PHYSICAL THERAPY & REHABILITATION

Specialists who care, Results that matter,
Helping you move through life!

Patient Name:_____

DOB: _____ Age: _____ Height: _____

Weight:_____ Currently working? ☐ **Y** ☐ **N** Occupation:_____

Referring Physician: _____

Primary Physician: _____

Last appointment with physician: _____

I have a history of or currently have (please check all that apply):

☐ **Arthritis**

☐ **Diabetes**

☐ **Heart trouble**

☐ **Poor circulation**

☐ **Asthma**

☐ **Parkinson's**

☐ **Alzheimer's**

☐ **Dementia**

☐ **Infections**

☐ **Recent weight loss/gain**

☐ **Dizziness**

☐ **High/Low blood pressure**

☐ **Severe pain at night**

☐ **Back injury**

☐ **Fractures**

☐ **Night sweats**

☐ **Tobacco use**

☐ **Depression**

☐ **Bowel/Bladder Issues**

☐ **Osteoporosis**

☐ **Stroke**

☐ **Cancer**

☐ **Headaches**

☐ **Pacemaker**

☐ **Hepatitis**

☐ **Infectious Disease**

☐ **Thyroid problem**

☐ **Allergies**

☐ **Pregnancy**

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Other: _____

Please list all of the medications you are currently taking (if not taking any please write none):

_____

_____

_____

_____

Have you had any hospitalizations within the past year? ☐ **Y** ☐ **N**

If yes please specify: _____

What surgeries have you undergone?

_____

_____

_____

Are you currently receiving physical therapy or home health treatments? ☐ **Y** ☐ **N**

When was your last visit? _____

Date of injury: _____

How did the injury occur?

_____

_____

_____

Have you had any of the following tests for this injury?

☐ **X-Ray** ☐ **MRI** ☐ **CAT** ☐ **EMG** ☐ **None** ☐ **Other**

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Is this injury a result of a fall? ☐ **Y** ☐ **N**

Have you had a fall within the past year? ☐ **Y** ☐ **N**

If yes, when? _____

Prior to your injury, what was your activity level? _____

What is your activity level now? _____

What are your goals for physical therapy?

_____

_____

_____

Which of the following best describes your symptoms?

☐ **Burning**	☐ **Pins and Needles**	☐ **Intermittent**
☐ **Numbness**	☐ **Dull**	☐ **Other:** _____
☐ **Constant**	☐ **Sharp**	

Please list activities that ***aggravate*** the injury or cause pain:

_____

_____

Please list activities that ***ease*** the pain:

_____

_____

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Please place a mark on the line below to indicate the intensity of your pain.

0 ——————————————— 5 ——————————————— 10

No Pain **Worst Possible Pain**

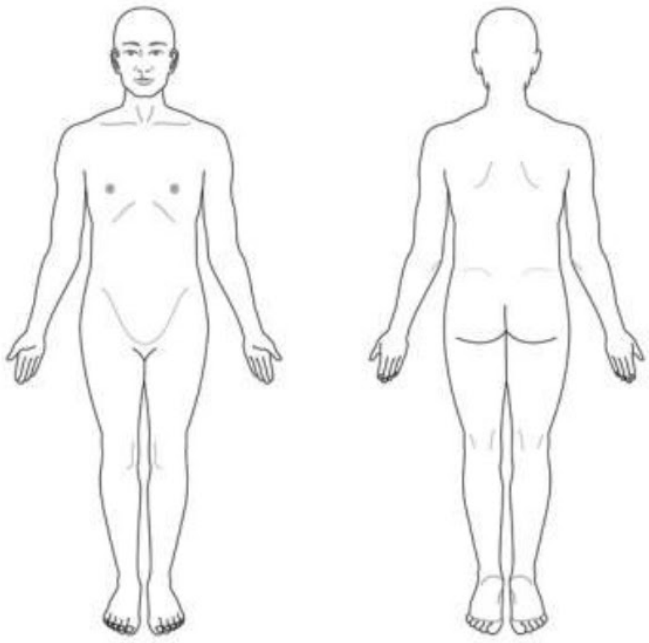
Mark the body images with the symbols below to indicate the types of pain at each location.

Moderate pain….....X

Severe pain…….....….*

Shooting/Stabbing pain…….....→

Numbness/Tingling pain……O



<u>Authorization for Physical Therapy Service</u>

I authorize the physical therapist of R.A. Physical Therapy and Rehabilitation to administer such treatment as is prescribed and considered therapeutically necessary based on the findings during the course of assessment and treatment. All anticipated risks and benefits of, and alternatives to my planned treatment will be discussed. It is my responsibility as a patient to ask questions or clarification of any treatment. I understand that it is my responsibility to immediately communicate any adverse or unexpected response to the specific modality, procedure or exercise

protocol. It is my responsibility to communicate all concerns that I have regarding my therapy with the staff at R.A. Physical Therapy and Rehabilitation.

As a condition of receiving physical therapy services, I agree to indemnify R.A. Physical Therapy and Rehabilitation against all claims, liabilities, losses, damages, suits, costs, and expenses (including reasonable attorney fees) relating to the physical therapy services rendered for my condition, unless such a claim is caused due to gross negligence or willful misconduct. I agree to assume all risk of property damage, injury such as strains/sprains associated with any physical therapy provided to me. The terms of this indemnification and assumption of risk policy shall survive the expiration date of any treatment.

The information provided is accurate to the best of my knowledge.

Patient Signature: _____

Print Name: _____

Date: _____