

# NIAGARA PHYSICAL THERAPY

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Name: Appointment (Date and Time):

Address: Diagnosis/ Problem:

Date of Birth: Insurance Company:

Male  Female ID#:

Phone Number: Referral Needed?

Occupation: Contact In Case of Emergency:

Physician: Phone Number:

## Current Condition(s)/Chief Complaint(s)

On a scale of 0-10(0-least 10-severe) rate your pain: at rest ( ), with activity ( ), at worst ( )

Describe the condition for which you seek therapy:

On what date did the condition begin?

Describe?

Have you had this condition before:  Yes  No

If yes, how did you treat it?

Did the condition get better?  Yes  No

How are you taking care of it now?

## Medical/Surgical History: Please check if you have ever had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Circulation             | <input type="checkbox"/> Head Injury             | <input type="checkbox"/> High Blood Sugar              |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Allergies               | <input type="checkbox"/> Low Blood Sugar               |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Blood Disorders         | <input type="checkbox"/> Skin Diseases                 |
| <input type="checkbox"/> Seizures                | <input type="checkbox"/> Lung Problems           | <input type="checkbox"/> Repeated Infections           |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Infectious Disease            |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Parkinson's Disease           |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Muscular Dystrophy            |
| <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Broken Bones/ Fractures | <input type="checkbox"/> Developmental/Growth Problems |
| <input type="checkbox"/> Ulcers/Stomach Problems | <input type="checkbox"/> Other Describe:         |  |

Have you had any Surgeries? Date?