

NIAGARA PHYSICAL THERAPY

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?