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	☐ Dementia	☐ Severe pain at night	☐ Bowel/Bladder issues	☐ Pacemaker
☐ Diabetes	☐ Infections	☐ Back injury	☐ Falls	☐ Hepatitis
☐ Heart trouble	☐ Recent weight loss/gain	☐ Fractures	☐ Osteoporosis	☐ Infectious Disease
☐ Poor circulation	☐ Dizziness	☐ Night sweats	☐ Stroke	☐ Thyroid problem
☐ Asthma	☐ High/Low blood pressure	☐ Tobacco use	☐ Cancer	☐ Allergies
☐ Parkinson's		☐ Depression	☐ Headaches	☐ Pregnancy
☐ Alzheimer's				

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 ☐

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

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

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

0 ——————————— 5 ——————————— 10

No Pain Worst Possible Pain

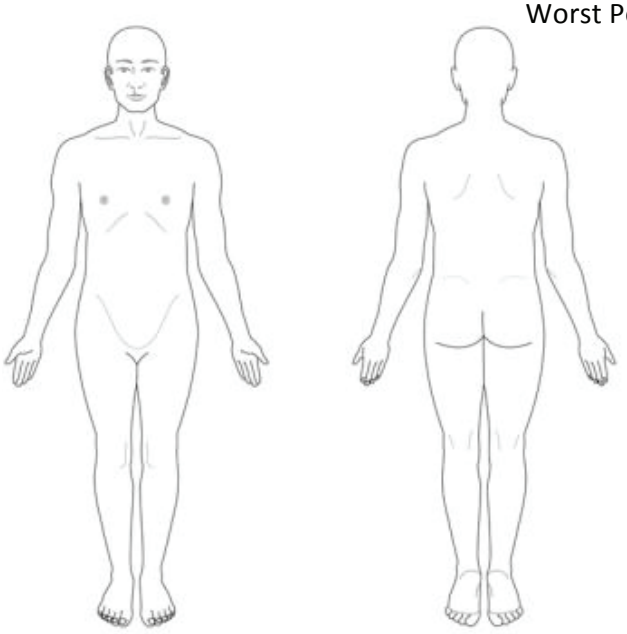
Mark the body images with the symbols below to indicate the types of pain at each location.

Moderate pain……X

Severe pain……*

Shooting/Stabbing pain……→

Numbness/Tingling pain……O



AUTHORIZATION FOR TREATMENT:
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 treatment.
The information provided is accurate to the best of my knowledge.

Signature:_____

Date: _____