Complete Body Physical Therapy

Date: _____ Name: _____Referring MD: _____

Height: _____ Weight: _____ Smoker: Y or N

Chief Complaints: _____

Current Medications: _____

Allergic to: _____

List any surgeries: _____

Have you had any recent diagnostic testing? ___ MRI ___ XRAY____ CT SCAN_____

Do you have any of the below conditions? Please rate pain during activities below:
Please Check/List your history: Scale 1=Mild 2=Mod 3=Severe 4=Unable

___ Heart Disease
___Pacemaker
___Stroke/TIA
___Blood Clot/Emboli
___Epilepsy/Seizures
___Infectious Disease
___Diabetes
___Cancer/Chemo/Radiation
___Arthritis
___Osteoporosis
___Headaches
___Vision or Hearing Impairment
___Pregnancy
___Other: _____
___Other: _____
___Other: _____

___Bending
___Changing Pos (sit to stand)
___Climbing Stairs
___Walking short distance
___Lifting over 5 pounds
___Lifting over 15 pounds
___Lifting over 25pounds
___Sleeping
___Personal Care
___Prolonged sitting
___Prolonged standing
___ Prolonged walking
___ Recreational activity
___Other:_____
___Other:_____
___Other:_____

I acknowledge that I have seen the "Notice of Privacy Practices" and may ask questions at any time and/or rescind my consent to medical release in writing at any time.

Signature: _____ Date: _____

I hereby agree and consent to medical treatment of my physical condition and authorize release of any medical information as necessary for my treatment and billing of claims.

Signature:_____ Date: _____