AARON D. ANDERS
PHYSICAL THERAPY

Patients Name: _____Age:_____DOB:_____Phone:_____

Employed: Full Time: _____ Part Time: ____ Unemployed: _____ Retired: _____Homemaker: _____ Student: _____Other:_____

Referred By: _____ Primary Care Physician: _____

Dominant Hand: Right: _____ Left: _____

Have you received Physical Therapy treatment this year? No / Yes When: _____ Where; _____

Are You Pregnant? No_____ Yes_____ Due Date: _____

Medical History: Check all that Apply

Arthritis: _____ Broken Bones/ Fractures: _____ Cancers: _____ Diabetes: _____ Heart Problems: _____

Lung Problems: _____ Osteoporosis_____ High Blood Pressure: _____ Parkinson's Disease_____ Stroke: _____

Head Injury: _____ Multiple Sclerosis: _____ Seizures: _____ Muscular Dystrophy: _____ Other: _____

Are you having any of the following symptoms? Please check all that Apply

Chest pains: _____ Loss of Balance: _____ Coordination Problems: _____ Pain at Night: _____

Difficulty Sleeping: _____ Visual Problems: _____ Headaches: _____ Weakness: _____

History of Current Problems:

Where is the area of pain / difficulty?
_____

When did this develop?
_____

How did this develop?
_____

Has this ever happened before?
_____

What makes it better?
_____

What makes it worse?
_____

Current Limitations: Please check all that Apply

Walking: _____ walking on rough ground: _____ Stairs: _____ Work / School: _____ Driving_____

Chores: _____ Shopping: _____ Recreational Activities: _____ Bathing: _____ Eating: _____ Dressing: _____

Prescription Medications: _____

_____

Surgical History: _____

_____

I will advise the Therapist if there are any changes in my physical condition that would altar my response to any of the above question.

Patient Signature: _____ Date: _____