

ORTHOPEDIC PHYSICAL THERAPY

Today's Date _____

Name _____ Gender _____ Ht _____ Wt _____ Age _____

Injured Body Part Right / Left _____ Injury Date _____

Referring Physician _____ Primary Care Physician _____

Other Medical Practitioners Seen for This Area / Condition _____

How Did Your Injury Occur? _____

Any Previous Injuries to This Body Area? _____ When / What? _____

Medical Treatment or Diagnostic Tests Received for This Condition to Date. (Circle All That Apply)

X-Ray MRI Specialist Injections Physical Therapy Surgery Chiropractic

Other _____

Are You Out of Work Because of This Injury? Yes _____ No _____

Has Your Physician Given You Any Activity Restrictions? Yes _____ No _____

Explain _____

Have You Had Any Major Injuries, Surgeries or Fractures, or Do You Have Any Medical Conditions That We Should be Aware Of? (e.g. Heart, Lungs, Blood Pressure, Diabetes, Cancer....)

Are You On Any Medications? (Please List) _____

Has Your Physician Ever Advised You Against Exercise? _____ If Yes, Why? _____

Do You Have Exercise Equipment at Home? Treadmill Bike Elliptical Trainer Free Weights

Other _____

I understand all of the questions asked of me and have honestly answered each.

Signature _____

Date _____