GLACKIN PHYSIOTHERAPY, LLC

Name: _____ DOB: _____
Height:_____ Weight_____
Occupation:_____
Primary Care Physician:_____

Currently I am experiencing (Circle all that apply):

Fevers/Chills/ Sweats	Poor balance (falls)	Unexplained weight loss/gain
Numbness/ Tingling	Changes in appetite	Difficulty Swallowing
Depression	Shortness of breath	Dizziness
Headaches	Malaise	Abnormal Heart Rate
Night Sweats/Pain	Nausea/Vomiting	Lightheadedness
Chest Pain	Swelling	Double Vision

Was this an automobile accident? Y or N. If yes, date: _____

Was this a work related accident? Y or N. If yes, date:
_____

Have you had any surgery(s)? Y or N. If so, list with dates: _____
_____
_____

Past Medical History: Have you been diagnosed with, felt, or took medication for any of the following:

____ High Blood Pressure	____Heart Disease or Heart Attack	____ High Cholesterol
____ Asthma	____ Allergies	____ Bronchitis
____ Blood Disorders	____ Emphysema	____ Anemia
____ Diabetes	____Hypoglycemia	____Concussion
____ Fainting	____ Anxiety/Panic attacks	____ Arthritis
____Hepatitis	____Kidney Disease/Stones	____ Spinal Cord Injury
____ Ulcers	____Traumatic Brain Injury	____Thyroid Problems
____Seizures	____ Bowel/bladder incontinence	____Abdominal Pain
____TMJ Disorder	____ Polio/Muscle Disease	____ Migraines/Headaches
____Blood in Stool	____Sleep Disorders	____ Lyme Disease
____Depression	____ Chronic Fatigue (Syndrome)	____ Fibromyalgia
____ Cancer	____ Gynecological Disorders	____ Fractures
____ Liver Disease	____ Sexually Transmitted Disease	____ Osteoporosis

Please answer the following questions:
1. Are you a smoker? Y or N If so, how long? _____ How many packs/day? _____
2. Do you drink? Y or N If so, how many drinks/wk? _____
3. Are you Pregnant? Y or N If so, what is your due date? _____
4. Are taking a blood thinner? Y or N
5. Do you have a pacemaker or any other medical transplant equipment? Y or N
6. If you answered "yes" to Cancer please list type(s):
_____
7. If you answered "yes" to fractures, please list type and date:
_____
8. Please list any pertinent family medical history:
_____

9. Have you noticed any of the following (circle):
Discoloration of urine, change of frequency, urgency, incontinence

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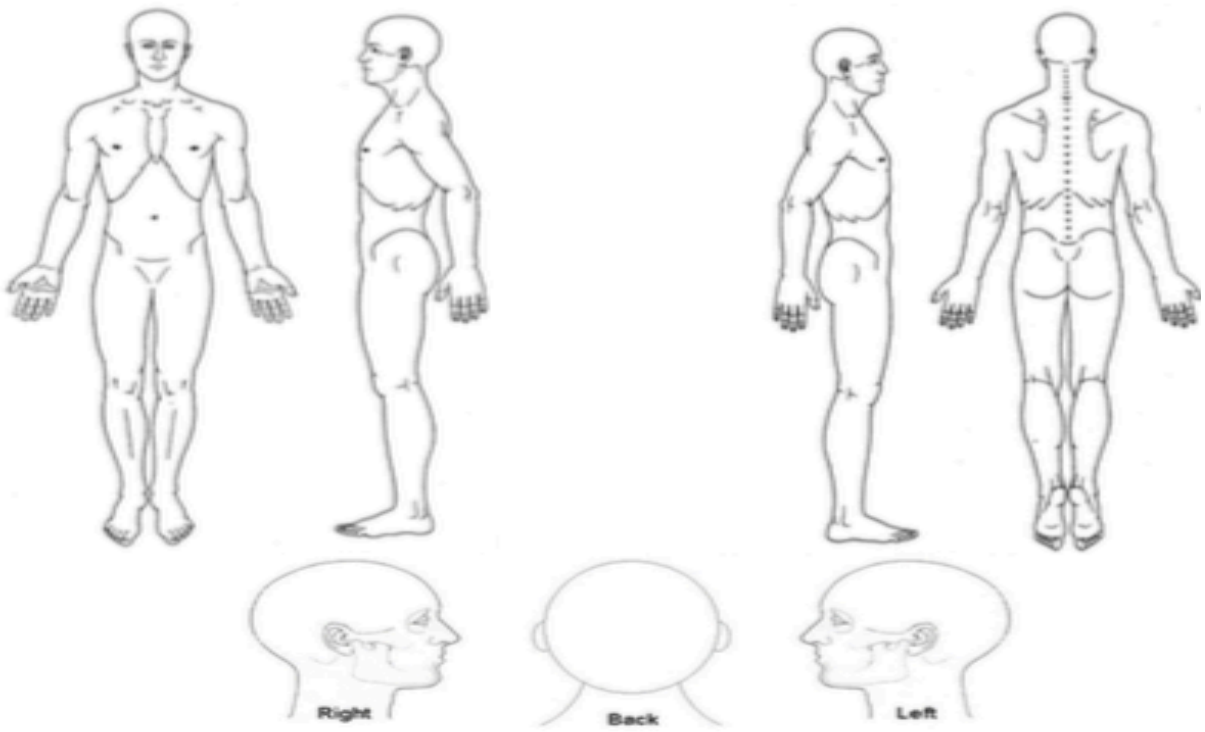
Please mark, with an 'X', the area (or areas) that you are currently experiencing discomfort:



This Section is meant to help us assess your current condition:

- About when did your pain/symptoms start?_____
  - Did your pain come on (circle one): **suddenly** or **gradually**
  - Was there injury/trauma? Y or N If yes, specify: _____
  - Are your symptoms (circle one): **Getting better** or **getting worse** or **about the same**
- Have you received treatment for this problem in the past? _____
  - If so, what treatment and did it help? _____
- Have you received any imaging (x-ray/MRI/etc)? Y or N
  - If yes, specify:_____

Please rate your pain on a scale of 0-10 (0 being no pain and 10 being the worst pain you can imagine)

Current ____/10 Worse over 72 hours ____/10 Best over 72 hours ____/10

- What makes your symptoms better?_____
- What makes your symptoms worse?_____

What are your personal goals for physical therapy?

_____

I have answered all questions to the best of my ability

Patient Signature: _____ Date:_____