ORTHOBETHESDA THERAPY SERVICES

Thank you for choosing us for your therapy needs! Please fill out this form completely. It is required by your insurance company and will assist the therapist that is evaluating your case. Please inform the front office staff if you need any assistance.

Name: _____ Height: _____ Ft. _____ In. Weight _____ Lbs.

What body part are you here for today? _____ ☐ Left ☐ Right

When did this problem begin? _____

Was there a specific injury? ☐ Yes ☐ No (if yes, please describe): _____

_____

Have you ever had physical therapy for this problem? ☐ Yes ☐ No

Have you had physical therapy this calendar year? ☐ Yes ☐ No

Have you had home care physical therapy for this problem? ☐ Yes ☐ No If yes, when were you discharged?

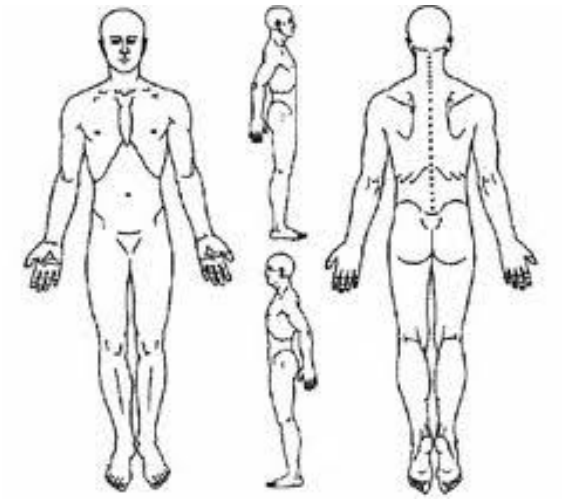
Is your injury work related? ☐ Yes ☐ No Is your injury related to a motor vehicle accident? ☐ Yes ☐ No

What is/are your main complaint(s)? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Balance loss ☐ Other: _____

If you have pain, please rate your pain on a scale of 0 to 10 with 0 being no pain and 10 being the worst imaginable:

At this current time: /10 Worst in the past 24 hours: /10 Best in the past 24 hours: /10

Please mark on the diagram with an **X** where it hurts
Please mark any areas of numbness with **O**



Medical History: Please check any conditions that you have

☐ Diabetes	☐ Stroke	☐ TIA (mini stroke)
☐ Heart Arrhythmia	☐ Coronary Heart Disease	☐ High BP
☐ Heart Attack	☐ High Cholesterol	☐ Depression
☐ Rheumatoid Arthritis	☐ Liver Disease	☐ Kidney Disease
☐ Neuropathy	☐ Acid Reflux	☐ Osteoarthritis

☐ Cancer Type: _____

☐ Other: _____

☐ **I do not have any medical problems**

List any orthopedic surgeries that you have had (including year):

_____

List any other surgeries that you have had:

_____

Are you allergic to latex? ***☐Yes ☐No*** **Do you have a pacemaker or defibrillator? ☐ Yes ☐ No** *Do you smoke? ☐Yes ☐No*

Do you exercise regularly? ☐Yes ☐No Female Patients: Is there any possibility that you are pregnant? ☐ Yes ☐ No

Review of Systems: Are you currently having, or have you had, problems with: ☐ None Numbness or Tingling? ☐ Yes ☐ No
Lungs or Breathing? ☐ Yes ☐ No Bleeding Disorders? ☐ Yes ☐ No Heart or Chest Pain? ☐ Yes ☐ No GI ulcers? ☐ Yes ☐ No

Do you have any medication, food or environmental allergies? ☐ Yes ☐ No If Yes, please list: _____

Diagnostic Testing: Have you had any of the following tests for you current problem:
☐ X-Ray ☐ MRI ☐ CT scan ☐ EMG / Nerve Conduction Study ☐ Other: _____
Results (if known):

Medications: Do you currently take any medications, vitamins, supplements or herbs: ☐ Yes ☐ No
If yes please fill out attached medication sheet or provide a current list.

Goals: Please list the goal(s) that you hope to achieve by attending physical therapy: _____

The above is true and correct to the best of my knowledge

Patient Signature:_____ Date:_____