



Patient Information Record

Name _____ Age _____

Diagnosis _____

Referring Physician _____ Family Physician _____

Occupation _____ How did you hear about our clinic? _____

Please answer the following questions about your present injury or illness:

1. How and when (date) did the present injury occur? _____

2. Was the onset gradual or sudden? _____

3. Have you had a recent: MRI _____ X-RAY _____ for this problem?

4. Did you undergo surgery? _____ If yes, the date of surgery: _____

5. Were you hospitalized? _____ If yes, for how long: _____

6. Describe current symptoms: _____

Are your symptoms: Improving? _____ Worsening? _____ Not Changing? _____

What activities/positions make your symptoms: Better _____

Worse _____

Please rate your pain on a scale from 0-10 with "0" pain free and "10" worst possible pain.

A. Pain level at this time _____

Numbness- ██████████

B. Pain at it's very worse _____

Pain- ***

C. Diagram where your symptoms are now. →

7. Have you ever had anything similar before?

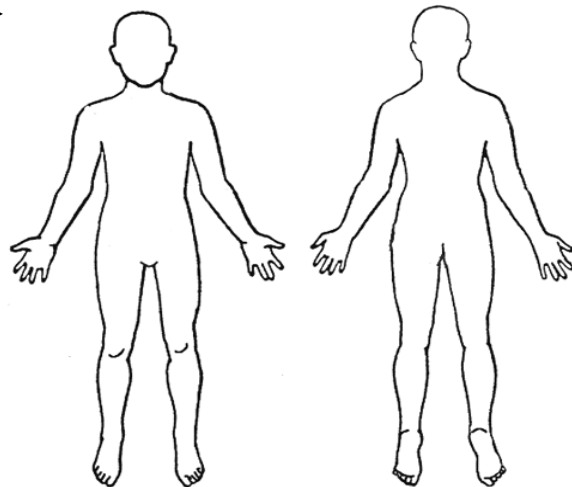
YES NO

8. Do you have bowel or bladder problems?

YES NO

9. Have you had previous Physical Therapy or Chiropractic treatments? _____

10. What are your goals for Physical Therapy?



Medical History

What medications are you currently taking? _____

DO YOU HAVE:

	YES	NO	Is it controlled?	YES	NO
High Blood Pressure?			YES		
Heart Disease?			YES		
Pacemaker?			YES		
Diabetes?			YES		
Bleeding/clotting disease (Hemophilia, Purpura)?			YES		
Dizziness, vertigo, nausea, blurred vision?			YES		
Respiratory illness?			YES		
Use of inhaled or oral steroids?			YES		
Metal implant(s)?			YES		
Current infection/fever?			YES		
Prostate problems?			YES		
Hormonal imbalance/problems?			YES		
Are you currently pregnant?			YES		
Osteoporosis?			YES		
Rheumatoid arthritis?			YES		
Allergies/material sensitivity?			YES		

HAVE YOU HAD:

Recent unexplained weight loss?	YES	NO
Previous head trauma or repeated convulsions?	YES	NO
Previous abdominal surgeries?	YES	NO
Previous surgery for head, neck or spine?	YES	NO
Previous shoulder injury?	YES	NO
Previous knee injury?	YES	NO
Previous ankle injury?	YES	NO
Recent bone fractures?	YES	NO
Recent falls?	YES	NO
Hysterectomy?	YES	NO
History of cancer?	YES	NO

Do you exercise or perform vigorous activity at least 3 times a week? YES NO

If so, what activities? _____

Do you know of any reason why you should not participate in a regular exercise program?

Please list any/all medical conditions/concerns. _____

The above information is correct to the best of my knowledge.

I agree that LODI PHYSICAL THERAPY may furnish the Insurance Company with whatever information it desires concerning said PHYSICAL THERAPY services. I also agree, should the amount be insufficient to cover the entire PHYSICAL THERAPY expense, I will be responsible to said PHYSICAL THERAPIST for payment of the difference; and if the nature of the disability be such that it is NOT COVERED by the policy, I will be responsible to the PHYSICAL THERAPIST for payment of the entire bill.

SIGNATURE (parent if minor) _____ Date _____