



# ORTHOPAEDIC SPORTS SPECIALISTS PHYSICAL THERAPY

## Patient Information/Health History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of onset, injury, or surgery \_\_\_\_\_

Have you had other treatment for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Are you taking any medication now? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes please list all medications: **MEDICATIONS LIST**  
If you need to, please continue your medications list on the back.

Do you now, or have you ever had, any of the following:

|                                  |       |                      |       |       |
|----------------------------------|-------|----------------------|-------|-------|
| Diabetes                         | _____ | High Blood Pressure  | _____ | _____ |
| Heart Disease                    | _____ | Heart Attack         | _____ | _____ |
| Pacemaker                        | _____ | Migraine Headaches   | _____ | _____ |
| Kidney Problems                  | _____ | Nervous Disorders    | _____ | _____ |
| Allergies to Heat                | _____ | Allergies to Ice     | _____ | _____ |
| Hernia (Ventral, Inguinal, etc.) | _____ | Seizures             | _____ | _____ |
| Metal Implants                   | _____ | Dizziness            | _____ | _____ |
| Cancer                           | _____ | Pregnant (currently) | _____ | _____ |

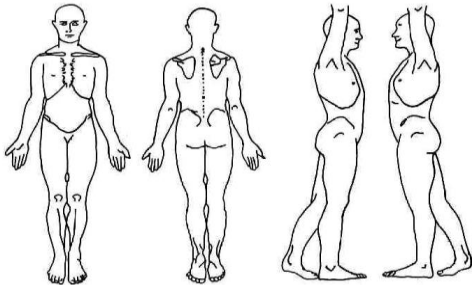
Previous Surgery for \_\_\_\_\_

Any other medical conditions the Physical Therapist should be aware of: \_\_\_\_\_

If yes to any of the above, please explain on back and give approximate dates.

I certify to the best of my knowledge, the above information is correct. I understand I am entering into a physical therapy program as prescribed by Dr. \_\_\_\_\_ for treatment in the diagnosis of \_\_\_\_\_. My next Doctor visit is scheduled for \_\_\_\_\_.

### Pain Chart & Questionnaire



Please mark the body charts to the left in the areas where you experiencing pain related to today's therapy visit.

Briefly Describe your pain: \_\_\_\_\_  
\_\_\_\_\_

Please rate your pain on a scale of 0-10 (0 being no pain, 10 being hospitalizing pain)

0    1    2    3    4    5    6    7    8    9    10

I do hereby discharge, release, and hold harmless **ORTHOPAEDIC SPORTS SPECIALISTS** and/or any of its personnel from any and all liability for injuries that may be sustained resulting from a condition I may suffer from participation, provided the injury is not the result of intentional negligence on the part of **ORTHOPAEDIC SPORTS SPECIALISTS** and/or any of its personnel.

I have read, understand, and agree to the above.

Signature \_\_\_\_\_

Date \_\_\_\_\_