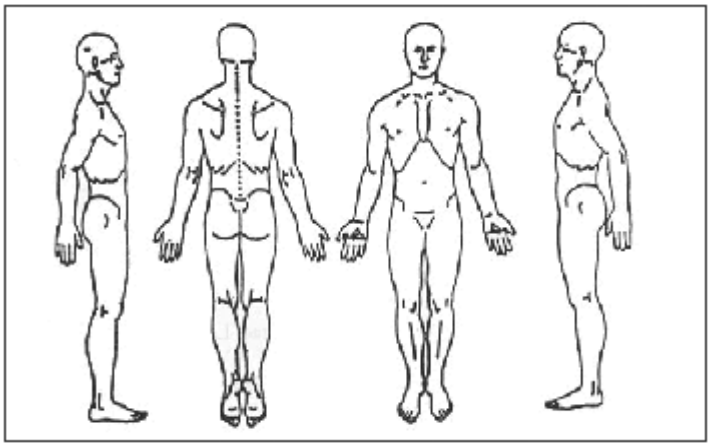
HUDSON VALLEY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY
~ Health ~ Education ~ Prevention ~

NAME: _____ Date: _____
DOB: ____/_____/_____ Occupation: _____ Currently working? Y / N

Chief Complaint/What brings you to physical therapy today? _____
_____
If more than one complaint, which is limiting you the most? _____
When did your symptoms start? _____
Are your symptoms related to an accident or specific injury? Y / N If yes, then describe:_____
_____

Please check all that describe your symptoms:
Pain: □ Sharp □ Aching □ Throbbing □ Tingling
□ Dull □Burning □ Boring □ Radiating □ Other: _____
Location of Pain: Please draw pain areas on diagram below.



Pain Intensity: (0 = No pain)
0 1 2 3 4 5 6 7 8 9 10
What makes symptoms better?
_____
What makes your symptoms worse?
_____
Are your symptoms: □ Getting better
□ Getting worse
□ Staying the same

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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Loss of Balance: Y / N Have you fallen recently? Y / N If yes, how many falls in the last year? ____

Have any of your falls resulted in injury? Y / N If yes, what was your injury? _____

Are any of your activities limited as a result of your injury? Y / N If yes, please explain: _____
_____

Are you currently receiving any treatment for this condition from:

Orthopedist: Y / N	Neurologist: Y / N	Physiatrist: Y / N
Physical Therapist: Y / N	Occupational Therapist: Y / N	Osteopath Y / N
Massage Therapist: Y / N	Chiropractor: Y / N	Other: _____

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Personal/Family Medical History: Have you or an immediate family member been diagnosed with:

	Self	Family Member
Anemia	Y / N	Y/ N
Asthma	Y / N	Y/ N
Angina/Chest Pain	Y / N	Y/ N
Cancer	Y / N	Y/ N
Chemical Dependency	Y / N	Y/ N
Circulation problems	Y / N	Y/ N
Depression	Y / N	Y/ N
Diabetes	Y / N	Y/ N
Emphysema	Y / N	Y/ N
Epilepsy/Seizures	Y / N	Y/ N
Heart Attack	Y / N	Y/ N
Hepatitis	Y / N	Y/ N

	Self	Family Member
Hypertension	Y / N	Y/ N
Hypoglycemia	Y / N	Y/ N
Kidney Stones	Y / N	Y/ N
Multiple Sclerosis	Y / N	Y/ N
Osteoarthritis	Y / N	Y/ N
Osteoporosis/Osteopenia	Y / N	Y/ N
Polio	Y / N	Y/ N
Rheumatoid Arthritis	Y / N	Y/ N
Stroke	Y / N	Y/ N
Thyroid Condition	Y / N	Y/ N
Tuberculosis	Y / N	Y/ N
Ulcer/Stomach Issues	Y / N	Y/ N

Other:		

Are you currently pregnant? Y / N ***PLEASE CONTINUE ON REVERSE SIDE. Thank you.***

Medical Testing: Have you had any of the following tests within the last year?

☐ Bloodwork ☐ CT Scan ☐ EMG/NCV ☐ MRI ☐ Stress Test ☐ Urinalysis

☐ X-Ray ☐ **Other _____**

Surgical History: Please list any surgeries including the approximate date and reason for the surgery.

DATE	Reason for surgery	DATE	Reason for surgery
1. _____	_____	4._____	_____
2. _____	_____	5._____	_____
3. _____	_____	6. _____	_____

Medications: Please indicate the medications' name, dosage, frequency, and route of administration. Please list all PRESCRIPTION medications you are currently taking (including pills, injections, and/or skin patches):

1._____ 4._____

2._____ 5. _____

3. _____ 6. _____

Have you taken any Over-the-Counter medications in the last week? Please indicate the name, dosage, frequency, & route of administration.

Advil/Motrin/Ibuprofen……..... Yes / No
Aspirin……. Yes / No
Antihistamines……. Yes / No
Vitamins/Mineral Supplements…… Yes / No
Antacids…… Yes / No
Tylenol……. Yes / No
Laxatives……... Yes / No
Other_____
(If yes, please list:_____
_____

Social History/Current Level of Fitness:

Do you live: ☐ Alone ☐ with Spouse ☐ with Family ☐ Other _____

Do you require assistance with activities of daily living? (Bathing, dressing, cooking, etc? Y / N) If yes, please list what you require help with: _____.
How many stairs inside your place of residence? _____

Do you exercise regularly? Y / N If yes, how many time per week? _____

Please describe your exercise:_____

How much caffeinated coffee or caffeinated beverages do you drink per day? _____

Do you smoke? Y / N If yes, how much per day do you smoke?_____

If you drink alcohol, how much per week do you drink? _____

Please list allergies or reactions to foods or medicines: _____

_____

Have you recently noticed any of the following:

Dizziness/ loss of consciousness Y / N
Fatigue Y / N
Fever/chills/sweats Y / N
Nausea/vomiting Y / N
Unexplained weight loss/gain Y / N
Weakness Y / N

What are your Physical Therapy goals?

1._____

2._____

3. _____

PATIENT SIGNATURE_____ **DATE**_____

PHYSICAL THERAPIST SIGNATURE _____ **DATE** _____