GOTHAM PHYSICAL THERAPY

Name: _____

On a scale of 0 to 10, with 0 being no pain and 10 being the worst, please rate your pain:
At best in the past week _____ **At worst in the past week** _____ **Currently** _____

What is your main complaint and reason for seeking help? _____

_____

_____

How do you think this problem began? _____

_____

_____

Surgery Date (if applicable): _____

Your symptoms are… (circle one) **Improving** **Worsening** **Staying the same**

Have you had these symptoms before? Please describe: _____

_____

_____

Do you have or have you had any of the following (circle answer):

Allergies (other than seasonal)	Yes No	High/Low Blood Pressure	Yes No
Anemia	Yes No	High Cholesterol	Yes No
Asthma	Yes No	HIV/AIDS	Yes No
Angina/Chest Pain	Yes No	Kidney Disease	Yes No
Cancer	Yes No	Liver Disease	Yes No
Depression/Anxiety	Yes No	Lung Disease	Yes No
Diabetes	Yes No	Multiple Sclerosis	Yes No
Dizziness/Fainting	Yes No	Osteoporosis/Osteopenia	Yes No
Epilepsy/Seizures	Yes No	Pacemaker	Yes No
Fibromyalgia/Chronic Fatigue	Yes No	Rheumatoid Arthritis/Other Rheumatism	Yes No
Fractures	Yes No	Sleep Difficulty	Yes No
Gout	Yes No	Stroke or TIA	Yes No
Chronic headaches/Migraines	Yes No	Thyroid Problems	Yes No
Heart Disease	Yes No	Ulcers	Yes No
Hemophilia	Yes No	Unexplained Weakness	Yes No
Hepatitis	Yes No	Vision difficulties	Yes No

Recent unintended weight change ..... Yes No
Recent changes in bowel or bladder function ..... Yes No
Are you pregnant? ..... Yes No

If yes to any of the above, please explain: _____

_____

_____

Any other past medical history not yet explained?_____

Please list all medications you are currently taking:_____

If your condition were resolved tomorrow, what would you most want to do?_____

OTHER THAN pain relief, what are your main goals for coming to physical therapy?

1._____
2._____
3._____
4._____
5._____

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