Patient Information

Name:_____ **Age**_____ **Sex**_____ **Date**_____

Height_____ **Weight**_____

Diagnosis:_____ **Physician**_____

Medications: Please list with frequency and dosage.

Medication	Frequency	Dosage

Medical History: Please check any medical conditions that apply to you

Cancer		Rheumatoid Arthritis	
High Blood Pressure		Stroke (CVA)	
Heart Conditions		Seizures	
Pulmonary/Lung Conditions		Hiatal Hernia	
Diabetes		Blood Clots	
Osteoporosis		Pregnancy	
Pacemaker		Other:	

Please describe the problem that brings you to therapy._____

_____

_____

Have you had surgery? (if yes, what was the date)_____

If "0" is no pain and "10" is the worst imaginable pain, your pain is currently_____

Your symptoms are (please circle):

constant	intermittent
better with movement	worse with movement
worse in the morning	worse at night

Have you received treatment for this problem before?_____By whom?_____

Have you had any diagnostic tests? (MRI, X-ray, etc.)_____

Are you currently taking nutritional supplements?(ie glucosamine, multivitamin) Yes___No____

Occupation?_____ Are you currently working?_____

What are your goals for therapy?_____

_____

Please supply your email address:_____

How did you hear about TheraSport Physical Therapy?_____