

## Kingston Physical Therapy & Sports Rehab., P.C.

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*www.KingstonPT.com*

Name:		Employer:	
Street:		Work Phone:	
City:	State:	Zip:	Family Physician:
Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Referring Physician:
Cell:	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Rx:
Email:	Height:	Weight:	Date of Incident/Accident:
DOB:	In Case of Emergency (Name):		
SS:	In Case of Emergency (Tel):		

Do you have any allergies?  Yes  No → If yes, please list allergies: \_\_\_\_\_

Please list medications: \_\_\_\_\_

Do you take any prescription medications?  Yes  No → If yes, please list: \_\_\_\_\_

Do you take any non-prescription medications? (check all that apply)

- |  |   |                                   |   |   |
|--|---|-----------------------------------|---|---|
| <input type="checkbox"/> Advil / Aleve | <input type="checkbox"/> Decongestants        | <input type="checkbox"/> Antacids | <input type="checkbox"/> Herbal supplements | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Tylenol       | <input type="checkbox"/> Ibuprofen / Naproxen | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Other: _____       |   |

Have you taken any medications previously for the condition for which you are seeing the physical therapist today?  Yes  No

→ If yes, please list: \_\_\_\_\_

Date of the last complete physical exam: Month / Year \_\_\_\_/\_\_\_\_ Physician: \_\_\_\_\_

Please check if you have ever had: (check all that apply)

- |   |   |   |  |                                     |
|---|---|---|--|-------------------------------------|
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Osteoporosis                     | <input type="checkbox"/> Shortness of breath / Asthma | <input type="checkbox"/> Lung problems/COPD        | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Heart attack / M.I.              | <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Parkinson's               |                                     |
| <input type="checkbox"/> Multiple sclerosis             | <input type="checkbox"/> Circulation or vascular problems | <input type="checkbox"/> Head aches                   | <input type="checkbox"/> Diabetes/high blood sugar |                                     |
| <input type="checkbox"/> Ulcers or stomach problems     | <input type="checkbox"/> Gall bladder                     | <input type="checkbox"/> Bowel problems               | <input type="checkbox"/> Vision problems / glasses |                                     |
| <input type="checkbox"/> Hearing problems               | <input type="checkbox"/> Back pain                        | <input type="checkbox"/> Urinary / kidney problems    | <input type="checkbox"/> Anxiety / panic disorders | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hepatitis / AIDS               | <input type="checkbox"/> Difficulty sleeping              | <input type="checkbox"/> Muscular dystrophy           | <input type="checkbox"/> Stroke                    |                                     |
| <input type="checkbox"/> Other: _____                   |   |   |  |                                     |

Please explain if you have or ever have had:  Prosthesis / implants  Cancer  Broken bones / fractures  Previous accidents

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Within the past year, have you had any of the following symptoms? (check all that apply)

<input type="checkbox"/> Heart problems	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Dizziness / blackout	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Developmental / growth problems	
<input type="checkbox"/> Weight loss / gain	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Weakness in arms/legs	<input type="checkbox"/> Head injury
<input type="checkbox"/> Low blood sugar	<input type="checkbox"/> Pain at night	<input type="checkbox"/> Joint pain/ swelling	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Fever / chills / sweats	<input type="checkbox"/> Seizures / epilepsy	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Infectious disease	

Other: \_\_\_\_\_

Have you ever had surgery?  Yes  No

→ If yes, please describe, and include dates:      Month / Day / Year      Month / Day / Year

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_      \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_      \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

For men only: Have you been diagnosed with prostate disease?       Yes  No

For women only: Have you been diagnosed with:

Pelvic inflammatory disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endometriosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with your period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Complicated pregnancies/deliveries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant, or think you may be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other gynecological or obstetrical difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No

→ If yes, please describe: \_\_\_\_\_

Family History: (Indicate which family member and age of onset if known.)	Heart disease:	Cancer:
	Hypertension:	Psychological:
	Stroke:	Arthritis:
	Diabetes:	Osteoporosis:
	Other:	Other:

Exercise:	Do you exercise beyond normal daily activities and chores? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe the exercise: _____ _____
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Hobbies:

General Health Status:	Please rate your health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Do you currently smoke tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No No. of Packs/Day: _____ No. of Cigars/Day: _____	Caffeine: How many caffeinated drinks or caffeine-containing beverages do you drink per day? _____	Alcohol: How many days a week do you drink alcohol? _____
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Current Conditions/Chief Complaints

Describe the problem(s) for which you seek physical therapy / What happened?

When did the problem(s) begin: Month / Day / Year  
  /   /

Have you ever had the problem before?  Yes  No  
 → If Yes: What did you do for the problem?  
 \_\_\_\_\_  
 \_\_\_\_\_

Did the problem get better?  Yes  No  
 How long did the problem last? \_\_\_\_\_

What makes the problem better?

What makes the problem worse?

What are your goals for physical therapy?

Are you seeing anyone else for the problem?  Yes  No

Acupuncturist       Occupational therapist       Cardiologist  
 Orthopedist       Chiropractor       Osteopath  
 Dentist       Pediatrician       Podiatrist  
 Family practitioner       Primary care physician       Internist  
 Massage therapist       Rheumatologist       Neurologist  
 OB/Gyn       Other: \_\_\_\_\_

10. Pain Questionnaire

Please mark an "X" in the area which best indicates your current pain level:

0 10

← NO PAIN WORST POSSIBLE PAIN →

Where is your pain?  
 Please mark an "X" on the drawings below where you feel your pain.

Please describe and rate your pain:

	NONE	MILD	MODERATE	SEVERE
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shooting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gnawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot-Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Splitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiring – Exhausting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punishing – Cruel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you:	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed			
Occupation:				
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Outside Home <input type="checkbox"/> From Home	<input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	<input type="checkbox"/> Homemaker <input type="checkbox"/> Student
Education:	Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 (circle one) <input type="checkbox"/> Some college / technical school <input type="checkbox"/> College graduate <input type="checkbox"/> Graduate school / advanced			
Living Environment:	Does your home have:	Do you use:	Where do you live:	With whom do you live?
	<input type="checkbox"/> Stairs, no railing <input type="checkbox"/> Stairs, railing <input type="checkbox"/> Ramps <input type="checkbox"/> Elevator <input type="checkbox"/> Uneven terrain <input type="checkbox"/> Assistive devices (e.g., bathroom) <input type="checkbox"/> Obstacles	<input type="checkbox"/> Cane <input type="checkbox"/> Walker or rollator <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Motorized wheelchair <input type="checkbox"/> Glasses, hearing aides <input type="checkbox"/> Other: _____	<input type="checkbox"/> Private home <input type="checkbox"/> Private apartment <input type="checkbox"/> Rented room <input type="checkbox"/> Board & care / Assisted <input type="checkbox"/> Living / Group home <input type="checkbox"/> Long-term care facility (Nursing home) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse only <input type="checkbox"/> Spouse and children <input type="checkbox"/> Other relatives <input type="checkbox"/> Group setting <input type="checkbox"/> Personal care attendant <input type="checkbox"/> Other: _____

Functional status / Activity level (check all that apply)

<input type="checkbox"/> Difficulty with movement <input type="checkbox"/> Bed mobility <input type="checkbox"/> Transfers (moving from bed to chair, from bed to commode) <input type="checkbox"/> Gait (walking): <input type="checkbox"/> On level <input type="checkbox"/> On ramps <input type="checkbox"/> On stairs <input type="checkbox"/> On uneven terrain	<input type="checkbox"/> Difficulty with self-care (e.g.: bathing, dressing, eating, toileting) <input type="checkbox"/> Difficulty with home management (e.g.: household chores, shopping, driving/transportation, care of dependents) <input type="checkbox"/> Difficulty with community and work activities / integration <input type="checkbox"/> Work / school <input type="checkbox"/> Recreation or play activity <input type="checkbox"/> Other: _____
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Clinical tests: Within the past year, have you had any of the following tests? (Check all that apply and indicate location of test(s) below.)

- |                                     |                                      |   |                                      |                                    |  |
|-------------------------------------|--------------------------------------|---|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Angiogram  | <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Biopsy         | <input type="checkbox"/> Blood tests | <input type="checkbox"/> Bone scan | <input type="checkbox"/> Bronchoscopy            |
| <input type="checkbox"/> CT scan    | <input type="checkbox"/> Doppler US  | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> EEG         | <input type="checkbox"/> EKG       | <input type="checkbox"/> EMG                     |
| <input type="checkbox"/> Mammogram  | <input type="checkbox"/> MRI         | <input type="checkbox"/> Myelogram      | <input type="checkbox"/> NCV         | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> Spinal tap | <input type="checkbox"/> Stool tests | <input type="checkbox"/> Stress test    | <input type="checkbox"/> Urine tests | <input type="checkbox"/> X-rays    | <input type="checkbox"/> Other: _____            |

Location of test(s): \_\_\_\_\_  
 \_\_\_\_\_

**If you are under 18 years of age prior to treatment at this facility, your parent or legal guardian must sign the statement of informed consent below, permitting Kingston Physical Therapy & Sports Rehab., P.C., to provide physical therapy care.**

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_.

I hereby permit Kingston Physical Therapy & Sports Rehab., P.C., to provide physical therapy to the above-mentioned minor.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_