Integrative Physical Therapy of Long Island, PLLC

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Name:			DOB:
Address:			City, State, Zipcode:
Phone:			Email:
Emergency Contact:			Phone:
Age:	Height:	Weight:	Occupation:
Household Occupants:			Stairs? (Y or N)
Activities/Sports/Exercise:			
Have you ever received physical therapy before? If so, when?:			
How did you hear about us:			

Tobacco use: _____ Alcohol Consumption: _____

What brings you here today? _____

When did this begin? _____

Have you had surgery for this? (Y or N) _____ Type of Surgery: _____

If Yes please indicate: Date: _____ Facility: _____ Surgeon: _____

How does this affect your daily function? _____

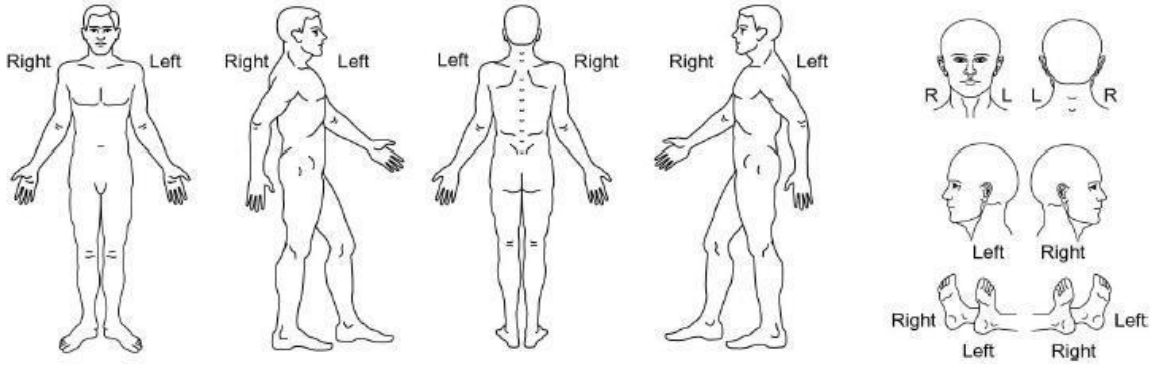
How does this affect your recreational activities: _____

Grade your Pain Level: At rest: 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10

Activity: 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10

Please mark location(s) with appropriate letter(s):

D = dull S = sharp TH = throbbing SH = shooting B = burning T = tingling N = numbness



How often do you have pain?

☐ Constant 76 - 100% of the time ☐ Frequent 51-75% ☐ Intermittent 26-50% ☐ Occasional less than 25%

Please list any diagnostic tests that you have undergone for this (i.e.: x-ray, MRI, CT scan, EMG, nerve conduction, ultrasound, etc.) _____

Have you received treatment for this in the past? (Y or N) _____

If yes, indicate type: ☐ PT ☐ OT ☐ MD ☐ Chiropratic ☐ Acupuncture ☐ Other _____

When: _____

Past Medical History

☐ High blood pressure
☐ Stroke
☐ Seizure disorder
☐ HIV
☐ Hepatitis
☐ Kidney Disease
☐ High Cholesterol
☐ Migraines / Headaches
☐ Pacemaker
☐ Other _____

☐ Heart Condition _____
☐ Autoimmune _____
☐ GI / Digestive: _____
☐ Diabetes: _____
☐ Arthritis: _____
☐ Pregnancy: _____
☐ Cancer: _____
☐ Emotional Disorder: _____
☐ Respiratory: _____

Any known allergies: _____

Stress Level:	☐ None	☐ Mild	☐ Moderate	☐ Severe	
Disturbed Sleep:	☐ None	☐ Mild	☐ Moderate	☐ Severe	Falls? _____
Balance Deficit:	☐ None	☐ Mild	☐ Moderate	☐ Severe	Frequency? _____
Altered Gait:	☐ None	☐ Mild	☐ Moderate	☐ Severe	Injury? _____
Weight Gain:	☐ None	☐ Mild	☐ Moderate	☐ Severe	

Past Surgical History (or bring list)

1) _____	Date:	_____
2) _____	Date:	_____
3) _____	Date:	_____
4) _____	Date:	_____
5) _____	Date:	_____

Current Medications and/or Supplements (or bring list)

1) _____	Dose:	_____	Frequency:	_____
2) _____	Dose:	_____	Frequency:	_____
3) _____	Dose:	_____	Frequency:	_____
4) _____	Dose:	_____	Frequency:	_____
5) _____	Dose:	_____	Frequency:	_____
6) _____	Dose:	_____	Frequency:	_____
7) _____	Dose:	_____	Frequency:	_____
8) _____	Dose:	_____	Frequency:	_____
9) _____	Dose:	_____	Frequency:	_____
10) _____	Dose:	_____	Frequency:	_____