Synergistic Physical Therapy

Name: _____ Today's Date:_____Date of Injury: _____

Phone Number: _____(**HOME/WORK/CELL**) Alternate Phone: _____

Home Address:_____ City/State:_____ Zip Code: _____

Date of Birth:_____ Email:_____ SSID:_____

Emergency Contact:_____Relationship: _____Phone: _____

How did you find us? _____

**If referred by a physician, please give physician's name

Height: _____ Weight: _____

Is your visit due to an accident? **YES NO** Type of Accident: **AUTO WORK SPORT OTHER**
Date of accident: _____

Have you had any surgeries? **YES NO**
Please list: _____

_____

Do you have any allergies? **YES NO**
Please list: _____

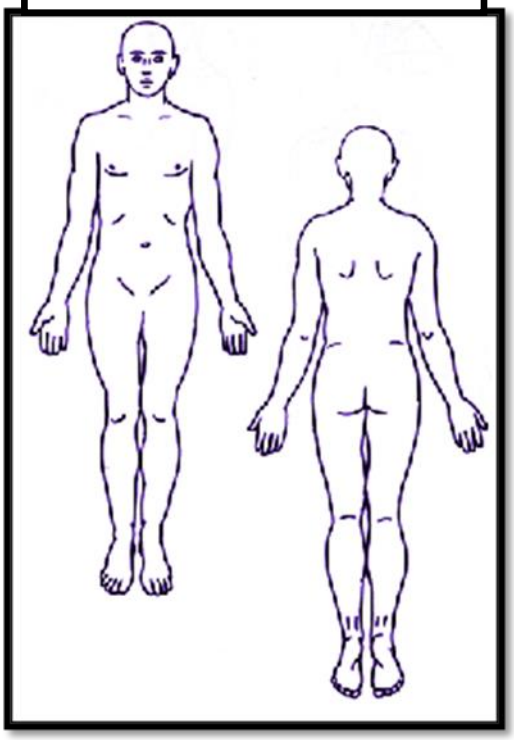
Are you taking any medications? **YES NO**
Please list: _____

_____

Do you have a history of falling? **YES NO**
When was your last fall?_____

Are you or could you be pregnant? **YES NO**
When is your due date? _____

Please circle the areas where you are experiencing symptoms:



Please rate your pain (circle one):

	(none)					(moderate)					(severe)
CURRENT:	0	1	2	3	4	5	6	7	8	9	10
WORST:	0	1	2	3	4	5	6	7	8	9	10
BEST:	0	1	2	3	4	5	6	7	8	9	10