2024 Subjective Patient Information

Please complete the following information. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant. Thank you.

_____
Patient Name

_____ _____ _____
Current Age Height Weight

Who recommended you to this office: _____

Diagnosis/Main problem:_____

Do you use an assistive device? If yes, what kind: _____

Main Complaints/Challenges

in order of their importance

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

Physical Therapy Goals

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

FSPT Buffalo
2564 Walden Ave, Suite 105
Cheektowaga, NY 14225
P| 716-288-7427 F| 716-288-7425

FSPT Marietta
965 Piedmont Rd., Suite 200
Marietta, GA 30066
P| 770-575-2212 F| 770-575-2547

FSPT Roswell
402 Bombay Ln.
Roswell, GA 30076
P| 678-878-2503 F| 678-878-2505

FSPT Fayetteville
500 W. Lanier Ave., Suite 303
Fayetteville, GA 30214
P| 770-716-8885 F| 770-716-7425

Pain

Location(s) of Current pain and level 1-10 (0= none, 5= moderate, 10= extreme) :_____

_____

_____

What makes your pain worse? _____

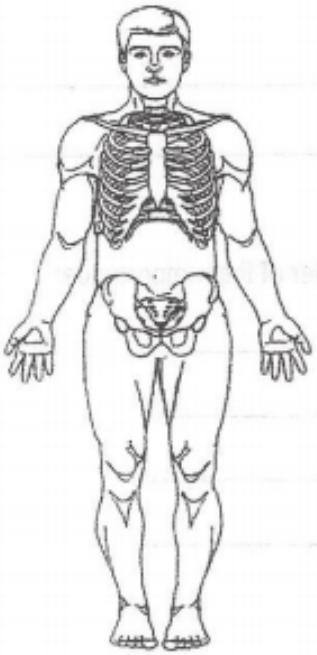
_____

What makes your pain better?_____

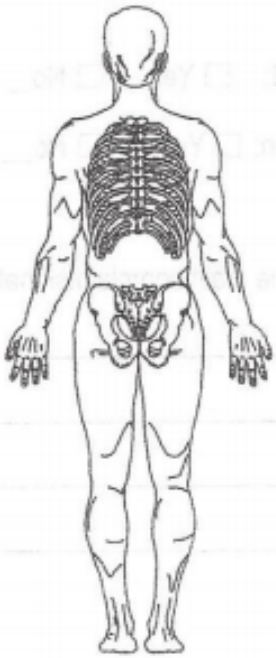
_____

Please shade in all areas of pain.

Front



Back



Medical History

Previous History of Similar Symptoms? ▢ YES ▢ NO

Are you a current patient of Home Health Care: ▢ YES ▢ NO

History of Falls: ▢ YES ▢ NO

Please Check all that Apply:

▢ Alzheimer's	▢ Fibromyalgia	▢ Obesity
▢ Cardiovascular Disease	▢ Fracture/Suspected Fracture	▢ Osteoarthritis
▢ Cauda Equina Syndrome	▢ High Blood Pressure	▢ Parkinson's
▢ Cerebral Palsy	▢ History of Cancer in Self	▢ Rheumatoid Arthritis
▢ Cerebral Vascular Accident	▢ Huntington's	▢ Traumatic Brain Injury
▢ Current Infection	▢ Immunosuppression	▢ Unexplained Weight Loss
▢ Type 1 Diabetes	▢ Lupus	
▢ Type 2 Diabetes	▢ Muscular Dystrophy	

▢ Surgical History _____

▢ Previous Physical Therapy _____

▢ Diagnostic Test/Imaging (X-ray, MRI, CT, etc) _____

▢ Other _____

Physician Information

Please list the practitioners you'd like us to send your initial evaluation, progress notes and plans of care to:
If your practitioner works at multiple offices please list the location you see them MOST OFTEN:

Group/Location: _____ Practitioner: _____

Phone: _____ Fax: _____

Group/Location: _____ Practitioner: _____

Phone: _____ Fax: _____

Medications and Allergies

Please list any prescribed medication, over the counter medication, and/or supplements you are taking:

Name of Medication/Supplement	Dosage	How long have you taken medication/supplement?

Do you have any Medication allergies or Environmental allergies ?

Name of Medication or Environmental allergen:	Reaction:	Treatment: