SCHWARTZ
PHYSICAL THERAPY

PATIENT CONTACT INFORMATION:

Patient's Name (Last, First, MI):_____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F S.S. Number: _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Phone (☐ home ☐ cell or ☐ work): _____ Alt. Phone (☐ home ☐ cell or ☐ work): _____

If a patient is a minor: Parent/Guardian Name: _____ Phone:_____

Student Status: ☐ High School ☐ College ☐ Other _____

Who may we thank for referring you to our office? _____ Phone:_____

EMERGENCY CONTACT:

In case of an emergency who should be notified? _____ Phone:_____

Relationship to patient: _____ Alternate Phone: (☐ cell or ☐ work)_____

Name of Physician referring you for Physical Therapy: _____

Have you received care from another Healthcare Professional for this injury? ☐ YES / ☐ NO

If yes, please list name: _____ Phone:_____

Where is your problem? *(Check off all that apply for this visit.)* **Which Side?** ☐ Left / ☐ Right / ☐ Both

☐ Ankle ☐ Knee ☐ Hip ☐ Elbow ☐ Wrist ☐ Neck ☐ Upper Back ☐ Lower Back ☐ Other:_____

Did you have surgery for this condition? ☐ YES / ☐ NO If yes, when? _____ **Type of Sugery?**_____

Which is your dominant arm? ☐ Left / ☐ Right **Height:** _____ **Weight:** _____

Do you smoke? ☐ NO / ☐ YES If yes, how often? _____ **Do you receive Home Healthcare Services?** ☐ YES / ☐ NO

Have you had prior hospitalization? *(Please explain)* _____

Do you have a history of falls? ☐ NO / ☐ YES *(Please explain)* _____

Functional Limitations: *(Check off that apply)* ☐ Sleep ☐ Self Care ☐ ADL's (Activities of Daily Living)

☐ Reaching/Pulling/Pushing ☐ Lifting/Carrying ☐ Sitting/Standing ☐ Bending/Squatting ☐ Mobility/ Ambulation

Please indicate nature of your symptoms *(Check off one)* ☐ Burning/Sharp ☐ Dull/ Ache ☐ Throbbing/Shooting ☐ Numbness/Tinglir

How did you injure yourself?

☐ No injury, just started hurting ☐ Sports: _____ ☐ Motor Vehicle Accident

☐ Fall ☐ Work/Job **Is there a Workers Comp Claim?** ☐ YES / ☐ NO

How long have you had symptoms? _____ **Date of Injury:** _____

Briefly describe your injury:_____

Are you currently working? ☐ YES / ☐ NO **Name of Occupation:** _____ **Status:** ☐ F/T / ☐ P/T

☐ Light Duty ☐ Transitional ☐ Out of Work ☐ Retired ☐ Not Working ☐ Homemaker ☐ Out of work since: _____

Previous treatments for this injury: *(medications, injections, bracing, surgery, chiropractic, pain management)*

_____

X-Rays ☐ YES / ☐ NO Date: _____ **MRI** ☐ YES / ☐ NO Date:_____

CT Scan ☐ YES / ☐ NO Date: _____ **Doppler** ☐ YES / ☐ NO Date:_____