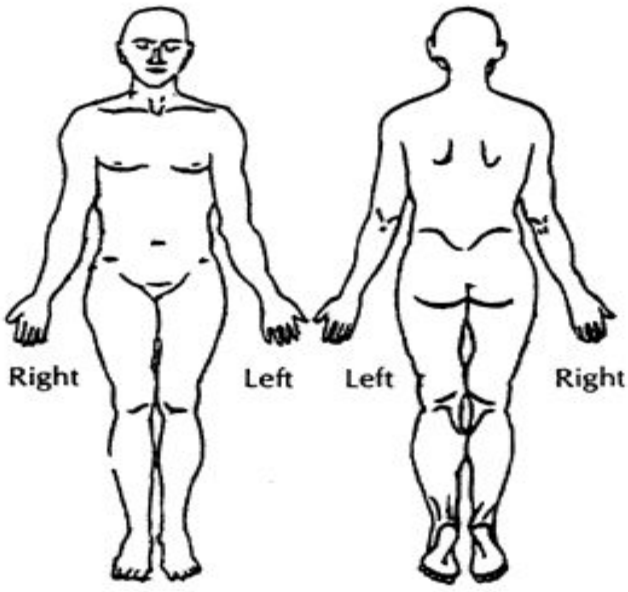
Sae Smyrl, PT ***Physical Therapy*** ***828-506-1157*** ***SylvaNCPT.com***

Please do your best to answer all questions below this line. Pt # _____ Location _____ Date_____

Name _____ Primary Care Provider _____
Parent/Guardian Name _____
Other types of treatments (circle) chiro/massage/acupuncture. _____
How did you hear about Sae Smyrl PT? _____
Address_____ Email _____
Phone _____Date of birth _____ Gender _____Age ___ Ht _____ Wt _____
Preferred way to receive brief messages such as appointment reminder (circle): Text? Email? Phone call?
Please confirm or question these appointments, so I know we're on the same page.
General health status (circle) excellent/good/fair/poor. _____
List current meds (or provide list I may copy) _____
Taking any blood thinning or anticoagulant meds? _____ NSAIDs? _____ Latex sensitive? _____
Are you pregnant or think you might be? _____ I smoke ___ pack/day. I drink _____ alcoholic drinks/wk.
I exercise ____ days/wk at (circle) low/med/high intensity (type of activity?)_____
Would you like help with general exercise/fitness? If so, goals?_____
Injuries and Surgeries, and approx dates _____
_____
Occupation/hours_____
**What is your primary concern and reason for seeking physical therapy today?_____
_____
When did this start? _____ What is this preventing you from doing that is important to you?
_____
Had any tests for this condition? _____ What type? (circle) Xray MRI CT injection blood work
Results?_____
Have you had any treatment for this condition, if so, what type? _____
Are symptoms getting worse, better, or same?_____What do *you* think is contributing to this problem?
_____
Personal goals for PT _____
PAIN: (from 0 to 10) Rate your current level of pain _____. In the past 3 days: Lowest ____. Highest ____.
(Circle) Constant or occasional?
Indicate how/where on the body chart. **X** sharp. **O** Dull/ache. **///** Throbbing. **++** Burning **::** Numb/tingling?



What makes it worse? _____ What makes it better? _____

Important Medical History

Please check and circle any conditions which you have had or are currently having and provide details if needed.

- ❑ Angina/Chest Pain Asthma
- ❑ Arthritis (osteo/rheumatoid/ other type _____)
- ❑ Blackouts
- ❑ Blindness
- ❑ Blood Clot
- ❑ Bowel or Bladder Problems (incontinence/leaking OR constipation/difficulty urinating)
- ❑ Carpal Tunnel Syndrome (left OR right)
- ❑ Chest/Abdominal Surgery
- ❑ Coronary Artery Disease
- ❑ Cancer (type_____)
- ❑ Chemical dependence
- ❑ Concussion OR brain injury
- ❑ Depression/Anxiety/Panic attack
- ❑ Diabetes (requiring medication or insulin injections?)
- ❑ Diverticulitis
- ❑ Ear Infections
- ❑ Endometriosis
- ❑ Fibroids
- ❑ Fibromyalgia
- ❑ Fractures _____
- ❑ Frequent Falls (fallen in the last 3 months?) _____
- ❑ Hearing Problems
- ❑ Heart Disease/heart attack/cardiac surgery? pacemaker/defibrillator?
- ❑ Hepatitis/liver problems
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV
- ❑ Hypoglycemia/low blood sugar/passing out
- ❑ Lung disease or difficulty breathing (asthma/emphysema/COPD)
- ❑ Menopause or Perimenopause
- ❑ Migraine (Headaches or other symptoms: VERY sensitive to light/sound/smells)
- ❑ Osteoporosis (losing bone density)
- ❑ Spinal Injury/surgery
- ❑ Polio/MS/neurologic disorders
- ❑ Seizure. When was recent one? _____
- ❑ Stroke
- ❑ Traumatic Injury/auto, motorcycle, work, sporting accident _____
- ❑ Vertigo/Spinning/light headedness _____

Anything else you want to report?

1. I agree to receive initial evaluation, treatment and education on my first appointment.

Patient or Parent/Guardian Signature_____ Date _____

2. I give permission to share results of this evaluation or other treatment records with my healthcare provider(s) _____, if requested.

Patient or Parent/Guardian Signature_____ Date _____

Now let's get you feeling better.