WELCOME TO NORFOLK PHYSICAL THERAPY

CONTACT INFORMATION

Last Name ______________ First ______________ MI ____ ☐ Male ☐ Female

Street Address ______________________ Date of Birth ______________

City ______________ State ______ Zip ________ SS# ______________

Phone: Home ______________ Work ______________ Cell ______________

Employer ______________________________ ☐ Full Time ☐ Part Time

☐ Retired ☐ Student Full Time ☐ Student Part Time School ______________

Spouse Name ______________________________

Spouse Employer/Work Phone ______________________________

In the case of an emergency, who would you like us to contact?

Emergency Contact ______________________ Phone ______________

PROVIDER AND TREATMENT HISTORY

Name of Healthcare Provider who referred you: ______________________

Name of Primary Care Physician: ______________________

Have you had ANY Physical Therapy for ANY condition in the last 3 years? ☐ YES ☐ NO
(Failure to provide prior treatment history may result in your treatment not being covered by your insurance).

In order for your therapist to best help you, please answer the following questions as best you can.

Today's Date ______________ Date of Onset (exact date is required for work injuries) ______________

Area of Injury or Pain: ______________________________

How did this injury occur? ______________________________

As it relates to this injury, please provide the dates of appointments with your healthcare provider:

Date of last appointment ______________ Date of next appointment ______________

What other treatment have you received for this problem? ______________________

What diagnostic tests have been done for this condition?

☐ X-ray ☐ CT Scan ☐ MRI ☐ Other ______________________

What type of work do you do? ______________ Are you on light duty? ☐ Yes ☐ No

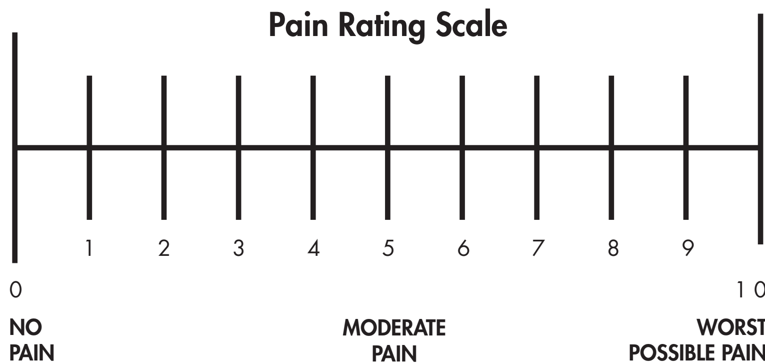
Have you lost time from work? ☐ Yes ☐ No ☐ Off work now due to injury ☐ Retired

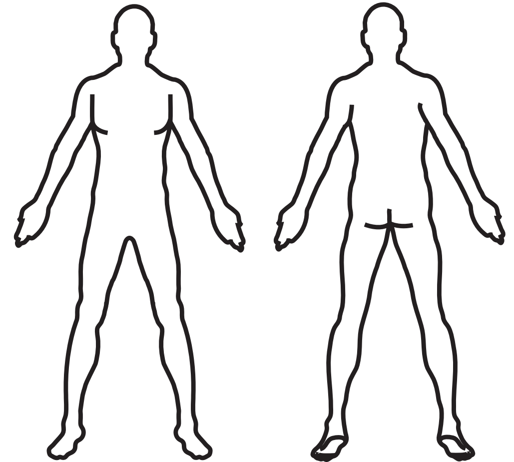
Please list 3 specific activities you have difficulty performing:
(Examples include dressing, doing dishes, housework, playing sports, gardening, playing with or lifting your children, specific work duties, sitting or standing for more than 10 minutes, unable to walk more than 20 min.)

1.______________________________ 2.______________________________ 3. ______________________________

Rate your average pain level below (circle one).

Mark on the body your pain locations.





Please list the following:
ALL medications you are currently taking:

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Any known allergies: ____

All major surgeries:____

Do you currently exercise? ☐ YES ☐ NO If yes, explain: ______________________________

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Indicate below if you have or had any of the following conditions:

Arthritis	Yes ☐	No ☐	Epilepsy or Seizures	Yes ☐	No ☐	Lung Condition	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Fractures	Yes ☐	No ☐	Migraines	Yes ☐	No ☐
Bleeding Dis.	Yes ☐	No ☐	Head Injury	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Blood clot	Yes ☐	No ☐	Heart Condition	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐	Hernia	Yes ☐	No ☐	Pinched Nerve	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Herniated Disk	Yes ☐	No ☐	Rheumatoid Arthritis	Yes ☐	No ☐
Depression	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐	Shortness of breath	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Latex Sensitivity	Yes ☐	No ☐	Smoking	Yes ☐	No ☐

Are you currently or have you recently been pregnant? Yes ☐ No ☐

If you have any disability that might interfere with safe exercise, please explain: ____________________

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If you have other conditions we may need to know about, please explain:____________________

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