Nina Silverman Physical Therapy
111 Maiden Ln Kingston NY 12401
P: (845) 331-8590 F: (845) 331-8595

Name_____ Referring Physician_____
Height_____ Date_____
Weight_____ Birth Date_____

Hand Dominance ____Left ____Right

MEDICAL HISTORY (check all that apply)

____Heart Disease	____Diabetes	___Lyme
____Cancer	____COPD	___Arthritis
____HIV/AIDS	____Asthma	___Parkinson's
____Multiple Sclerosis	____Hepatitis	___Epilepsy
____Osteoporosis	____Pregnant	___Fibromyalgia
____High Blood Pressure	____Thyroid	___Scoliosis
		___Stroke

Surgical Procedures (list)_____

List any medication you are taking:_____

Allergies (include medications)_____

What is your chief reason for coming to therapy?_____

When/ how did this injury or symptom begin?_____
_____
Have you had surgery for your condition? No___ Yes___ Date_____
List diagnostic tests? (i.e. X-ray, MRI, EMG…)_____

Please list past treatment for your condition_____
_____
Are you currently working? _____Yes _____No

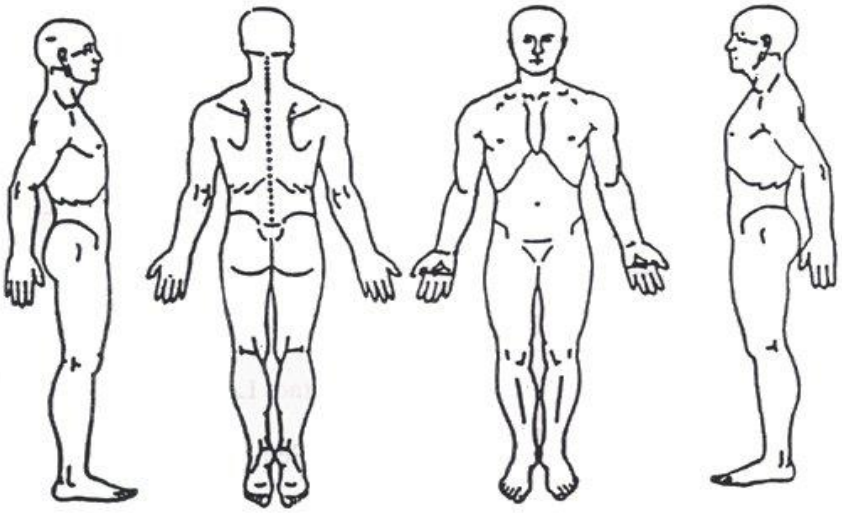
What job duties do you perform?_____
Are you on restricted duty? _____Yes _____No
Prior to this injury, describe your activity level: (i.e. walked independently, played golf, worked…)

_____

Please rate your ability to perform the following activities:
1. not limited 2. with some difficulty 3. with significant difficulty 4. unable

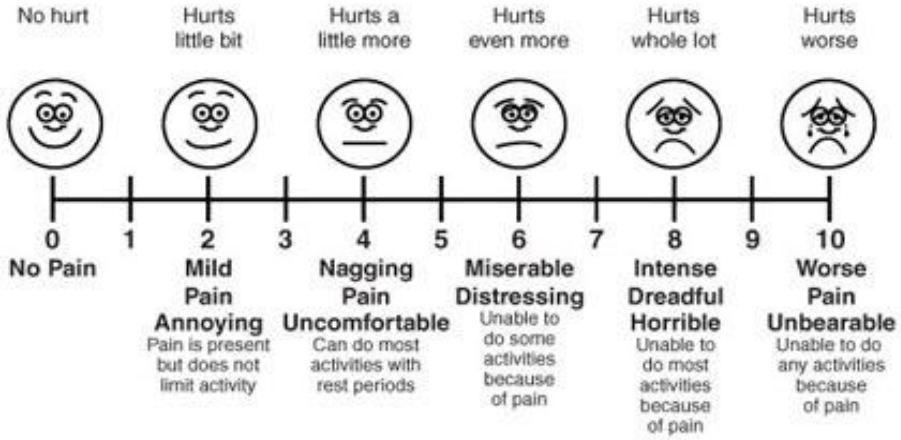
Sleeping___	Stairs_____	Yard work_____
Dressing___	Walking_____	Sexual Activity___
Sitting_____	Housework___	Sport Activities___
Standing___	Driving_____	Reaching_____

Where is your pain located? (Please indicate by marking the body chart below):



Is your pain intermittent or constant?_____
What makes your pain better?_____
What makes your pain worse?_____
How would you describe your current pain?_____
Achy___ Burning___ Sharp___ Throbbing___ Dull___ Radiating___

Please indicate your current pain level on the chart below:



Rate your least and worse pain level since your injury (0=no pain, 10=severe pain)
Least pain since onset_____ Worst pain since onset_____
Did you have pain prior to this injury? _____If yes, rate your prior pain level_____
What goals do you want to achieve with therapy?_____

When do you go back to your physician?_____
To the best of my knowledge, this information I have given is complete and accurate.
Patient's signature_____Date_____