PT Now Darren Beilstein, DPT, OCS, FAAOMPT

Questions above the "**BOLD LINE**" are ONLY in regards to today's visit

Name_____ **Referring Physician** _____

Date of first Dr visit for current pain/injury: _____ **Family Physician** _____

Last date worked due to current pain/injury: _____ **Date returned to work** _____

Is an Attorney involved in this case? **YES** **NO**

Have you had surgery for current pain/injury? **YES** **NO** **Number of surgeries:** _____

Type of surgery _____ **Took place in:** **Hospital** **Surgery Center**

Have you had any of the following Medical or Rehabilitative Services for this current pain/injury?

	YES	NO		YES	NO
Chiropractor			CT Scan		
EMG/NCV			General Practitioner		
Massage Therapy			MRI		
Myelogram			Neurologist		
Occupational Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room Care			X-Rays		
Other					

Are you currently taking any prescription or non-prescription medication? **YES** **NO**

Anti-inflammatory_____ **Muscle relaxers**_____ **Pain Medication**_____

List Medications: _____

Are you allergic to any medications? **YES** **NO**

List Medications:

Patient's Past Medical History

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema			Severe or Freq Headaches		
Shortness of Breath/Chest Pain			Vision/Hearing Difficulties		
Coronary Heart Disease/Angina			Numbness or Tingling		
Do you have a Pacemaker?			Dizziness or Fainting		
High Blood Pressure			Bowel or Bladder Problems		
Heart Attack or Surgery			Weakness		
Stroke/TIA			Weight Loss/Energy Loss		
Congestive Heart Disease			Hernia		
Blood Clot/Emboli			Varicose Veins		
Epilepsy/Seizures			Allergies		
Thyroid Disease or Goiter			Any Pins/Metal Implants		
Anemia			Joint Replacement Surgery		
Infectious Disease			Neck Injury/Surgery		
Diabetes			Shoulder Injury/Surgery		
Cancer or Chemo/Radiation			Elbow/Hand Injury/Surgery		
Arthritis			Back Injury/Surgery		
Osteoporosis			Knee Injury/Surgery		
Gout			Leg/Ankle Injury/Surgery		
Sleeping Problems			Are you pregnant		
Emotional/Psych Problems			Do you use tobacco		

List any other information that would assist us in your care: _____

Are you aware of your diagnosis and prognosis as explained by your doctor? **YES** **NO**

Based on your awareness, what are your rehabilitation expectations/goals while in this program:

Patient/Guardian Signature:_____ **Date:**_____