Patient Name_____ DOB_____

Genesee Valley Physical Therapy

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL OR REHABILIATIVE SERVICES FOR THIS CONDITION?

_____ X-Rays	_____ Emergency Room Care	_____ General Practitioner
_____ EMG / NCV	_____ Physical Therapy	_____ Neurologist
_____ CT Scan	_____ Occupational Therapy	_____ Orthopedist
_____ Myelogram	_____ Massage Therapy	_____ Podiatrist
_____ MRI	_____ Chiropractor	_____ OTHER

Have you ever had surgery for this condition? YES NO Date(s) of Surgery: _____

Are you currently taking any prescription or non-prescription medications? YES NO (circle) If yes, please list:

_____

_____

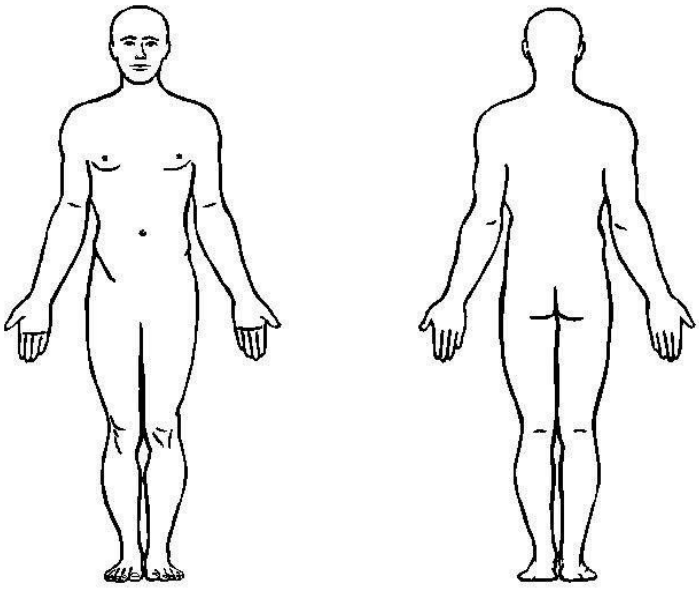
DO YOU NOW HAVE OR HAVE YOU EVER HAD *ANY* OF THE FOLLOWING?

_____ osteoporosis	_____ blood clot/emboli	_____ joint replacements
_____ asthma/breathing problems	_____ heart problems	_____ arthritis/joint problems
_____ diabetes (Type I or II)	_____ drug allergies (list)_____	_____ car accidents
_____ high blood pressure	_____ past physical therapy treatments	_____ epilepsy
_____ metal implants or pins	_____ cancer/chemo/radiation	_____ dizziness or fainting
_____ pregnancy	_____ brain/nervous system disorders	_____ numbness or tingling
_____ currently pregnant	_____ past surgeries	

_____ other _____

What is your current pain level? (0-10) _____
Have you fallen in the past year? YES NO If, YES, how many times? _____
Are you aware of what your diagnosis is? YES NO
What are your expectations/goals for rehabilitation? _____

Were you given a choice of physical therapy facilities to choose from? YES NO
If you have had physical therapy in the past, how was your experience? _____



Please shade on the drawings the areas where you feel pain, mark X's where you feel numbness and tingling.