Synergy Physical Therapy

New Patient Health History

Name: _____ DOB: _____ Date: _____

Emergency: Contact Name and Number: _____

Family Physician: _____ Referring Physician: _____

Diagnosis: _____ Primary Complaint: _____

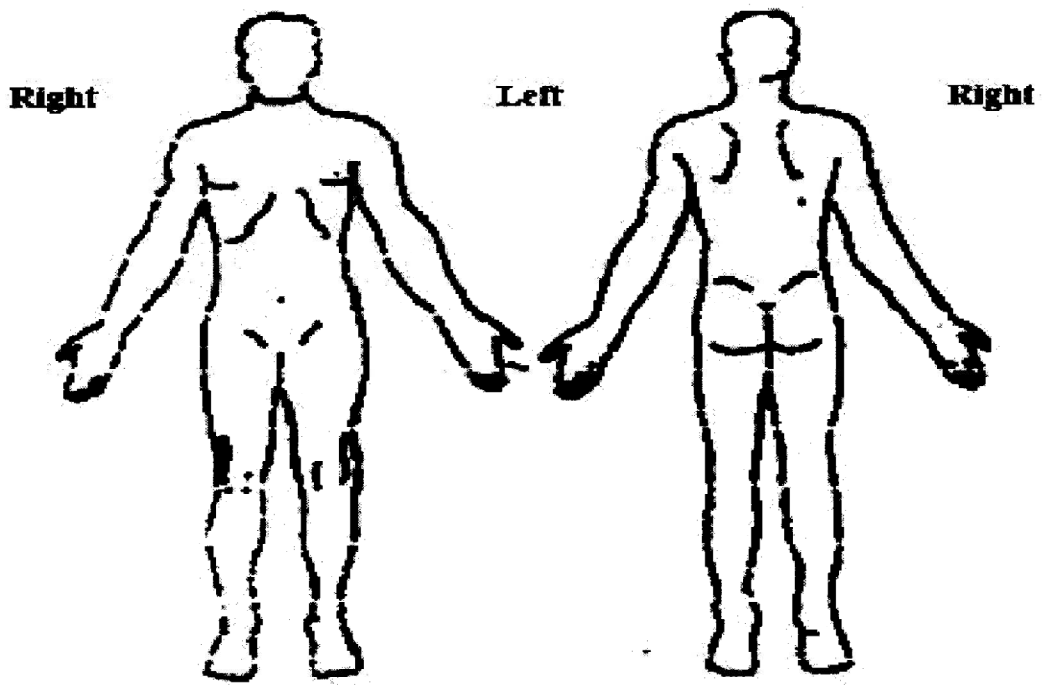
Date of injury: _____ Date of surgery: _____

Occupation: _____ Hobbies: _____

Pain: How would you rate your overall pain on a scale of 0 (no pain) to 10 (the worst)? 0-1-2-3-4-5-6-7-8-9-10

Pain: Scale (0-10) _____ at present _____ Best _____ Worst ◯ No complaints

Please Mark on the diagram below the location of your pain ◯ Right handed ◯ Left handed



When and what do you think initially caused your pain / symptoms? _____

_____

_____

Synergy Physical Therapy

Patient Name: _____

DOB: _____

Since the start of this episode, has the pain changed or moved? _____

Have you had outpatient therapy (occupational, physical, or speech) for this injury in the past? __ ____yes __ _____ NO

If yes, when and where did you have it, and how many sessions? _____

_____

Have you had any body work done in the past year? If yes where and when_____

Medications:

Name of medication	Purpose of medication
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Medical history: Circle all that apply

Allergies	Anxiety	Arthritis	Asthma
Blackouts	Blood Clots	Broken bones	Cancer
Depression	Diabetes	Dizziness	Hearing impairments
Head injury	Headaches	Heart Disease	High Blood pressure
Kidney disease	Lung Disease	Neurological Disorders	Osteoporosis
Pacemaker	Peripheral neuropathy	Pregnant currently	Seizures
Skin Disease	Stroke	Substance abuse	Surgery
Unexplained weight loss	Visual impairments		

Pleaseexplaincircleditems:_____

_____

_____

_____

How would you rate your overall health? ◯ Excellent ◯ very Good ◯ Good ◯ Fair ◯ Poor

How much time in a day are you willing to spend to get better? _____

What are your goals for coming here to Synergy Physical Therapy? _____

_____

How did you hear about Synergy Physical Therapy? _____

Patient or Guardian Signature: _____ **Date:** _____