5318 Highgate Drive, Durham, NC 27713

(919) 237-3802 phone / (919) 237-3807 fax

Chart #: _____

NAME: _____ DATE: _____

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE ( )_____ WORK PHONE ( )_____ CELL PHONE ( )_____

EMAIL ADDRESS: _____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME: _____ RELATIONSHIP: _____

HOME PHONE ( )_____ WORK ( )_____ CELL ( )_____

REFERRING PHYSICIAN: _____ PHYSICIAN'S PHONE NUMBER: ( )_____

NEXT MD APPOINTMENT DATE: _____

FIT PHYSICAL THERAPY REQUIRES COPIES OF ALL INSURANCE CARDS & PHOTO ID TO PUT ON FILE

CHIEF COMPLAINT: _____

DATE OF INJURY/ONSET: _____

HISTORY OF INJURY/ONSET: _____

_____

ANYTHING SPECIFIC THAT AGGRAVATES PAIN/PROBLEM? _____

ANYTHING SPECIFIC THAT RELIEVES YOUR PAIN/PROBLEM? _____

LIST PRIOR TREATMENTS THAT YOU HAVE HAD FOR THIS CONDITION (i.e., Physical or Occupational Therapy, Injections, Chiropractic Treatment, etc.) _____

RATE YOUR PAIN ON A SCALE FROM 0 – 10 (0 = No pain at all; 10 = Worst pain imaginable) DURING THE FOLLOWING SCENARIOS:

- MY PAIN AT THIS MOMENT IS _____
- MY PAIN IS _____ MOST OF THE TIME DURING A NORMAL DAY
- MY PAIN IS _____ AT WORST
- MY PAIN IS _____ AT BEST

OCCUPATION/PRIMARY JOB DEMANDS (i.e., prolonged sitting/standing, computer work, lifting, pushing, pulling, uneven surfaces, etc…) _____

JOB STATUS: (Circle One) WORKING FULL TIME, REGULAR DUTY; WORKING FULL TIME, LIGHT DUTY; WORKING RESTRICTED HOURS, REGULAR DUTY; WORKING RESTRICTED HOURS, LIGHT DUTY; OUT OF WORK SECONDARY TO INJURY; UNEMPLOYED; RETIRED; NOT WORKING

RECREATIONAL ACTIVITIES: _____

MY PERSONAL GOAL(S) FROM PHYSICAL THERAPY ARE: _____

_____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (Please check all that apply):

_____ ALLERGIES (Specifically Tape, Creams/Lotions, Etc…)
(list) _____

_____ OSTEOARTHRITIS

_____ RHEUMATOID ARTHRITIS

_____ASTHMA

_____BLOOD CLOT

_____CANCER (what type) _____

_____DEPRESSION/ANXIETY

_____DIABETES

_____DRUG/ALCOHOL DEPENDENCY

_____EPILEPSY/SEIZURES

_____FIBROMYALGIA

_____GASTRIC REFLUX

_____GLAUCOMA

_____HEART ATTACK

_____HEART FAILURE

_____PACEMAKER

_____DEFRIBRILLATOR

_____REQUIRE USE OF NITROGLYCERIN

_____OTHER HEART PROBLEMS

_____HEPATITIS

_____HIGH BLOOD PRESSURE

_____HIV/AIDS

_____KIDNEY DISEASE

_____LUNG PROBLEMS

_____NURSING/BREASTFEEDING

_____STROKE/TIA'S

_____THYROID PROBLEMS

_____OSTEOPOROSIS

_____PREGNANCY

_____PSORIASIS

_____PREVIOUS CORTISONE INJECTION

_____PREVIOUS FRACTURES

_____PREVIOUS ORAL STEROID

_____OTHER PSYCHIATRIC PROBLEMS

_____UNEXPLAINED WEIGHT LOSS

_____LUPUS

_____ OTHER MEDICAL HISTORY _____

HAVE YOU EVER HAD ANY X-RAYS, MRI, CT SCANS, ETC., RELATING TO THIS CONDITION?____YES ____NO

RESULT (IF KNOWN): _____

PLEASE LIST ALL SURGERIES: _____

PLEASE LIST CURRENT MEDICATIONS (with dosages or bring a list to be placed in your file): _____

_____

HAVE YOU HAD ANY FALLS WITHIN THE PAST YEAR? _____YES _____NO

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES OF ANY TYPE? (i.e., nursing, aides, wound care, I.V., physical therapy, etc.)? ___YES ___ NO ___UNSURE (PLEASE EXPLAIN)_____