Panetta
Physical Therapy & Motion Specialists

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Visit us at www.panetta.com!

Please complete the following forms before being seen by a physical therapist. Answer as completely as possible.

Patient Name: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Other _____ Social Security #: _____

Address: _____

_____

Cell Phone: ( ) _____ Home Phone: ( ) _____ E-Mail: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ E-Mail

Referring Physician: _____ Primary Physician: _____

Employer: _____ Employer Phone: ( ) _____

Employer Address: _____

_____

Human Resource Contact Person: _____

History:

What problem brought you to physical therapy? _____

How did this problem begin? _____

What tests or treatment have you had for this problem? _____

Did you have surgery for this problem? ☐ Yes. ☐ No. Surgery Date: _____

What medications are you currently taking (include dosage)? _____

_____

With whom do you live? (check all that apply)

☐ Alone ☐Spouse/Significant other ☐Child/ Children ☐ Other relative(s)

☐ Group setting ☐Personal care attendant ☐ Other: _____

Where do you live?

☐ Private home ☐ Private apartment ☐ Rented room ☐ Assisted living/ group home

☐ Long term care facility (Nursing home) ☐ Other _____

Do you use a: (check all that apply)

☐ Cane? ☐ Walker, rolling walker or rollator?

☐ Manual wheelchair? ☐ Motorized wheelchair or scooter? ☐ Other

Do you have a history of the following? (Check all that apply.)

☐Heart condition ☐Diabetes ☐High Blood Pressure ☐Pacemaker ☐Asthma ☐Arthritis

☐Peripheral Vascular Disease ☐Dementia ☐Cerebro-Vascular Disease ☐Chronic Lung Disease

☐Connective Tissue Disease ☐Ulcer ☐Liver Disease ☐Stroke/CVA ☐Kidney Disease ☐Tumors

☐Back or Neck Pain ☐hip/ leg/ knee/ ankle pain ☐Shoulder Pain ☐Leukemia ☐Lymphoma

☐ Hand/Wrist Pain ☐Metastasis ☐AIDS ☐Other: _____

Please list any allergies you have: _____

Present Status:

What is your main symptom or problem? _____

_____

Are there any positions or activities that make your condition worse? _____

Are there any positions or activities that ease your condition? _____

Pain:

Where is your primary area of pain? _____

Describe the nature of your pain (aching, dull, radiating, sharp, etc.) _____

When did the pain begin? _____

How frequently do you have the pain?

☐ Rarely (less than 10% of the day) ☐ Occasionally (11-25%) ☐ Intermittently (26-50%)

☐ Frequently (51-75%) ☐ Constantly (76-100%)

Rate your major area of pain on a scale from 1-10. Circle the number that rates your pain at present.

Pain At Rest: 0 1 2 3 4 5 6 7 8 9 10

None Weak Moderate Strong Maximal

Pain With Movement: 0 1 2 3 4 5 6 7 8 9 10

None Weak Moderate Strong Maximal

Personal:

Are you currently employed? ☐ Yes ☐ No Are you currently working? ☐ Yes ☐ No

Please describe your occupation and physical demands: _____

Do you participate in any of the following? (Check all that apply.)

☐Golf ☐Bowling ☐ Tennis ☐Running ☐Swimming ☐Biking ☐Triathalons ☐Baseball/Softball

☐ Soccer ☐ Basketball ☐Volleyball ☐Cheerleading ☐Dancing ☐Martial Arts ☐Other: _____

Please describe your involvement in this activity: ☐ Casual/Hobby ☐ Amateur ☐ Professional

Do you belong to a club or league? ☐Yes ☐No. If yes, where? _____