SAN RAMON VALLEY PHYSICAL THERAPY

Patient Information Sheet

Please complete every section as best you can, even if you have completed it before.

Name: _____ Age: _____ Date: _____

Occupation: _____ Diagnosis: _____

Primary Physician:_____ Referring Physician:_____ Date of Onset: _____

Leisure Activity: _____ Circle: Right Left Handed

History

List all current medications (including over-the-counter):

_____

_____

Do you have now, or have you ever had, any of the following (please circle Y or N):

Diabetes	Y	N	Depression	Y	N	Bone Disease	Y	N
High Blood Pressure	Y	N	Gastrointestinal Problems	Y	N	Osteoporosis	Y	N
Pacemaker/Defibrillator	Y	N	Headaches/Migraines	Y	N	Fractures	Y	N
Heart Attack/Disease	Y	N	Kidney Problems	Y	N	Cancer	Y	N
Stroke	Y	N	Hernia	Y	N	Falls	Y	N
Bladder/Bowel Problems	Y	N	Neurological Disorders	Y	N	Numbness/Tingling	Y	N
Circulation Disease	Y	N	Recent Weight Loss	Y	N	Seizures	Y	N
Dizziness	Y	N	Allergy to Heat or Cold	Y	N	Sensitivity to Light	Y	N
Metal Implants	Y	N	Previous Surgery	Y	N	Current/recent pregnancy	Y	N
Latex Alergy	Y	N				If YES, DOB/Due date: _____		

If YES to any of the above, please explain and give appropriate details (use back if necessary):

_____

_____

Current injury information

Was your injury the result of an auto accident ? Yes _____ No _____

Was your injury work related? Yes _____ No _____

Are you off work as a result of this condition? Yes _____ No _____

Have you been treated elsewhere for this condition? Yes _____ No _____

If yes, where and describe: _____

Describe your main problem(s)

_____

_____

Please list any surgeries or tests (MRI, x-rays) ***relating to this injury only***

Surgery/Test Date Results

_____

_____

_____

If you have pain, please indicate the location _____ and level:

(least) 1 2 3 4 5 6 7 8 9 10 (most)

What activities make you feel worse ? _____

What do you do to feel better? _____

How did you hear about our clinic? _____