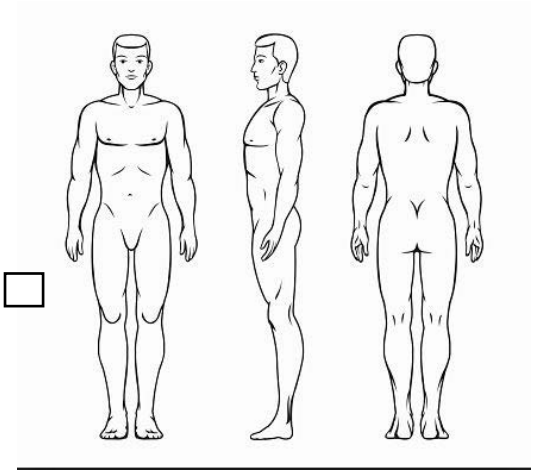
Rancho Del Mar
PHYSICAL THERAPY

Patient Name_____Today's Date_____
Date of Birth_____Age_____
Type of Injury/Condition_____
Date of Injury_____
Type of Surgery & Date_____
Who referred you to physical therapy? _____
Next Doctor's Appointment?_____
Describe previous treatment for this condition_____
_____



Have you received physical therapy treatment this year? YES ☐ NO ☐
Have you received speech therapy treatment this year? YES ☐ NO ☐
Have you received Home Health Care via Medicare this year? YES ☐ NO ☐
Are you currently pregnant? YES ☐ NO ☐

Have you had any imaging performed:
☐ X-Ray ☐ CT Scan
☐ MRI ☐ Doppler
☐ Ultrasound

Have you recently noted:

☐ Weight Loss/ Gain	☐ Nausea / Vomiting	☐ Fatigue
☐ Weakness	☐ Fever / Chills / Sweats	☐ Numbness / Tingling
☐ Pain with coughing/ sneezing	☐ Headaches	☐ Change In Vision Or Hearing
☐ Pain At Night	☐ Cramps In Legs When Walking	☐ Insomnia

Do you have now or have you had any of the following?

☐ Surgeries	☐ Loss of Consciousness	☐ Fractures
☐ Sprains / Strains	☐ Diabetes	☐ Blood Pressure Problems
☐ Heart Problems	☐ Cancer	☐ Pacemaker
☐ Circulation Problems / Clots	☐ Asthma / Breathing Problems	☐ Motor Vehicle Accident
☐ Easy Bruising / Bleeding	☐ Leg / Ankle Swelling	☐ Lung Disease
☐ Indigestion / Heartburn	☐ Fainting	☐ Urinary Problems / Infections
		☐ Allergies / Skin Sensitivity

☐ Any Previous Injury that may affect current care: _____
_____
Explain & give approximate dates for any items you indicated above_____
_____
Are you currently taking medications? YES ☐ NO ☐ Name or Type of Medication _____
_____

Type Of Pain: SHARP ☐ BURNING ☐ ACHING ☐ TINGLING ☐ NUMBNESS ☐ OTHER_____
Rate your pain (average) on a 1-10 scale (1=minimal 10=severe)_____

What do you expect to accomplish with physical therapy? _____
_____
_____