ACTION PHYSICAL THERAPY

3443 Huntingdon Pike
Huntingdon Valley PA, 19006
215-947-3443

Patient name: ____Date:___________________

Affected Body Part: ______________________ Date of next physicians visit: ___________________

Date of Injury/Onset: ________________________Date of Surgery (if applicable) _______________

Are you currently working? ________ Yes ________ No

Have you received any related therapy for this diagnosis? ________Yes ________No
Type of Therapy: ____________________________

Have you ever had these symptoms before? _______ Yes _______ No

Height: _______ Weight: _______

Check which apply to you

	yes	no		yes	no
Diabetes/Hypoglycemia			Poor Circulation		
Chest Pain/ Angina			Anemia/Blood Disorders		
High Blood Pressure			Osteoarthritis		
Heart Disease			Osteoporosis		
Heart Attack			Hernia		
Heart Palpitations			Seizure		
Pacemaker			Metal Implants		
Headaches			Dizziness/Fainting		
Kidney Problems			Fracture		
Cancer			Surgeries		
Stroke			Skin Abnormalities		
Bowel/Bladder Abnormalities			Nausea/Vomiting		
Urine Leakage			Rheumatoid Arthritis		
Asthma/Breathing Difficulties			Smoking		
Liver/Gallbladder Problems			Hereditary Disorders		
Infections or Infectious Disease			Other		

If you answered yes to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

____
____
____
____

Are you presently taking any medications? _______Yes _______No
If yes, please list what medications and for what conditions or attach a list

____
____

Do you have any allergies? _______Yes ________No
If yes, please list your allergies

____

Do you have Homecare? (A Nurse or a Physical Therapist coming to your house) ______Yes _______No

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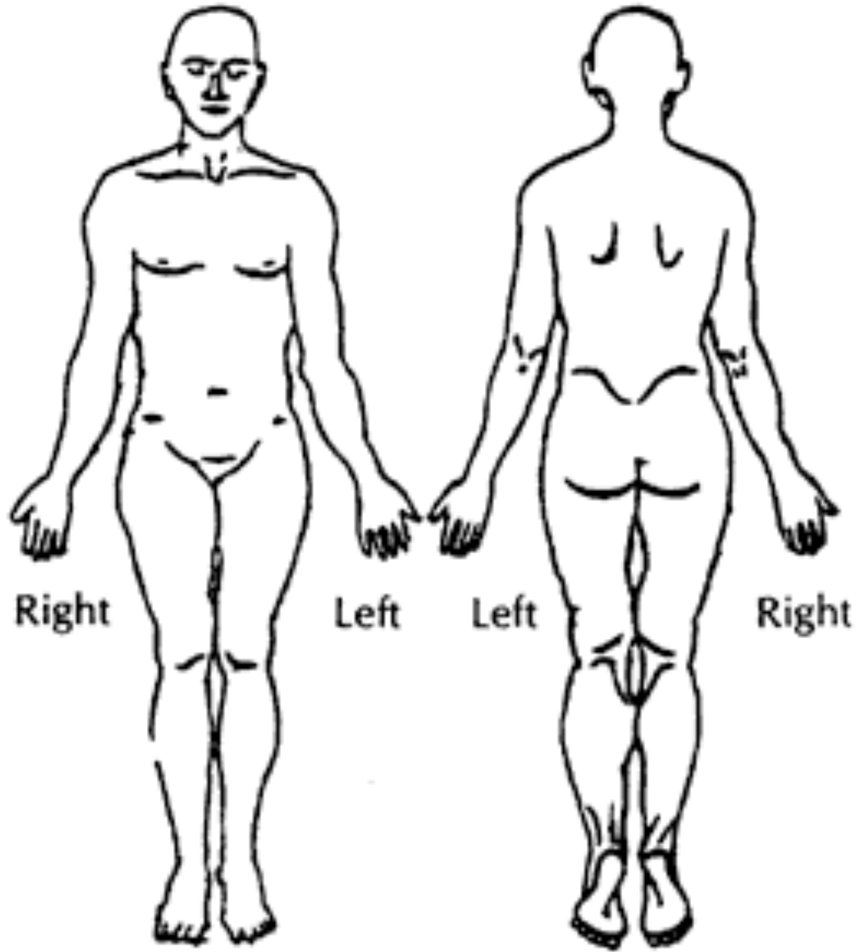
Do you participate in any sports, exercise programs or activities on a regular basis? ______Yes ______No
If so, list the type of activity: ____
____

Please indicate below where your symptoms are located:



If you have pain, please rate the intensity of your pain on a scale of 0-10 with 0 being no pain and 10 being the worst possible pain. Pain at rest _______ Pain with activity _______

Signature: ____ Date: ________________