Kingston Physical Therapy & Sports Rehab., P.C.

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Woodstock, NY 12498
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Name:				Employer:	
Street:				Work Phone:	
City:		State:	Zip:	Family Physician:	
Phone:		Sex: ☐ Male ☐ Female		Referring Physician:	
Cell:		Pregnant? ☐ Yes ☐ No		Date of Rx:	
Email:		Height:	Weight:	Date of Incident/Accident:	
DOB:		In Case of Emergency (Name):			
SS:		In Case of Emergency (Tel):			

Do you have any allergies? ☐ Yes ☐ No → If yes, please list allergies: ____________________

Please list medications: ____________________

Do you take any prescription medications? ☐ Yes ☐ No → If yes, please list:____________________

____

____

Do you take any non-prescription medications? (check all that apply)

☐ Advil / Aleve ☐ Decongestants ☐ Antacids ☐ Herbal supplements ☐ Antihistamines

☐ Tylenol ☐ Ibuprofen / Naproxen ☐ Aspirin ☐ Other: ____________________

Have you taken any medications previously for the condition for which you are seeing the physical therapist today? ☐ Yes ☐ No

→ If yes, please list:____________________

Date of the last complete physical exam: Month / Year _____/______ Physician: ____________________

Please check if you have ever had: (check all that apply)

☐ Arthritis ☐ Osteoporosis ☐ Shortness of breath / Asthma ☐ Lung problems/COPD ☐ Chest pain

☐ Congestive Heart Failure (CHF) ☐ Heart attack / M.I. ☐ High blood pressure ☐ Parkinson's

☐ Multiple sclerosis ☐ Circulation or vascular problems ☐ Head aches ☐ Diabetes/high blood sugar

☐ Ulcers or stomach problems ☐ Gall bladder ☐ Bowel problems ☐ Vision problems / glasses

☐ Hearing problems ☐ Back pain ☐ Urinary / kidney problems ☐ Anxiety / panic disorders ☐ Depression

☐ Hepatitis / AIDS ☐ Difficulty sleeping ☐ Muscular dystrophy ☐ Stroke

☐ Other: ____________________

Please explain if you have or ever have had: ☐ Prosthesis / implants ☐ Cancer ☐ Broken bones / fractures ☐ Previous accidents

____

____

____

Within the past year, have you had any of the following symptoms? (check all that apply)

☐ Heart problems ☐ Heart palpitations ☐ Cough ☐ Hoarseness ☐ Skin diseases

☐ Dizziness / blackout ☐ Difficulty walking ☐ Coordination problems ☐ Developmental / growth problems

☐ Weight loss / gain ☐ Nausea/vomiting ☐ Loss of balance ☐ Weakness in arms/legs ☐ Head injury

☐ Low blood sugar ☐ Pain at night ☐ Joint pain/ swelling ☐ Difficulty swallowing ☐ Loss of appetite

☐ Fever / chills / sweats ☐ Seizures / epilepsy ☐ Thyroid problems ☐ Infectious disease

☐ Other: ______________________________________

Have you ever had surgery? ☐ Yes ☐ No

→ If yes, please describe, and include dates: Month / Day / Year Month / Day / Year

____ ____ /____ / ____ ______________________________________ ____ /____ / ____

____ ____ /____ / ____ ______________________________________ ____ /____ / ____

For men only: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

For women only: Have you been diagnosed with:

Pelvic inflammatory disease? ☐ Yes ☐ No Endometriosis? ☐ Yes ☐ No

Trouble with your period? ☐ Yes ☐ No Complicated pregnancies/deliveries? ☐ Yes ☐ No

Pregnant, or think you may be pregnant? ☐ Yes ☐ No Other gynecological or obstetrical difficulties? ☐ Yes ☐ No

→ If yes, please describe:____________________________

Family History: (Indicate which family member and age of onset if known.)	Heart disease:	Cancer:
	Hypertension:	Psychological:
	Stroke:	Arthritis:
	Diabetes:	Osteoporosis:
	Other:	Other:

Exercise:	Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No	If yes, describe the exercise: ____________________ ____________________

Hobbies:

General Health Status:	Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Do you currently smoke tobacco? ☐ Yes ☐ No No. of Packs/Day: ________ No. of Cigars/Day: ________	Caffeine: How many caffeinated drinks or caffeine-containing beverages do you drink per day? __________	Alcohol: How many days a week do you drink alcohol? __________

Current Conditions/Chief Complaints

Describe the problem(s) for which you seek physical therapy / What happened?

When did the problem(s) begin: Month / Day / Year

☐☐ / ☐☐ / ☐☐☐☐

Have you ever had the problem before? ☐ Yes ☐ No

→ If Yes: What did you do for the problem?

____

____

Did the problem get better? ☐ Yes ☐ No

How long did the problem last? ______________________

What makes the problem better?

What makes the problem worse?

What are your goals for physical therapy?

Are you seeing anyone else for the problem? ☐ Yes ☐ No

☐ Acupuncturist	☐ Occupational therapist	☐ Cardiologist
☐ Orthopedist	☐ Chiropractor	☐ Osteopath
☐ Dentist	☐ Pediatrician	☐ Podiatrist
☐ Family practitioner	☐ Primary care physician	☐ Internist
☐ Massage therapist	☐ Rheumatologist	☐ Neurologist
☐ OB/Gyn	☐ Other: ______________________	

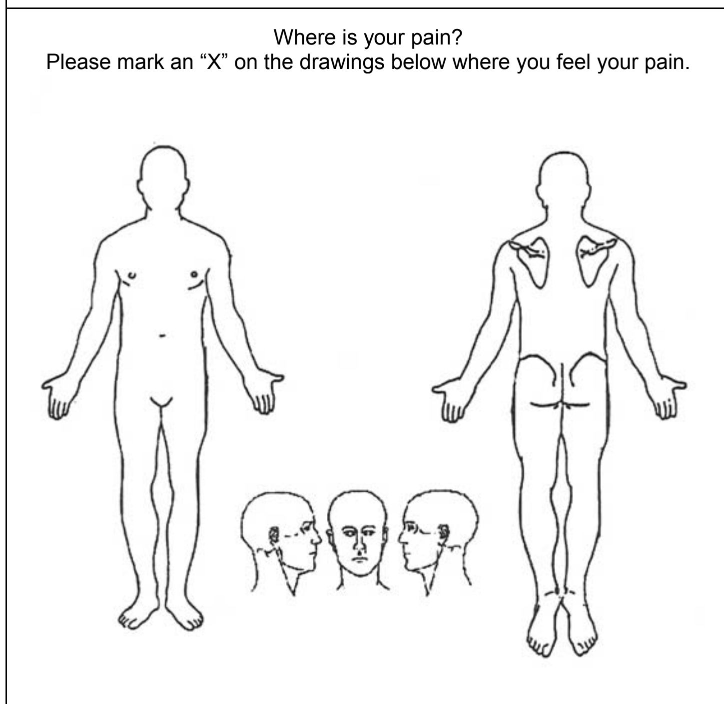
10. Pain Questionnaire

Please mark an "X" in the area which best indicates your current pain level:

0 ____ 10

← NO PAIN WORST POSSIBLE PAIN →

Where is your pain?
Please mark an "X" on the drawings below where you feel your pain.



Please describe and rate your pain:

	NONE	MILD	MODERATE	SEVERE
Throbbing	☐	☐	☐	☐
Shooting	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐
Sharp	☐	☐	☐	☐
Cramping	☐	☐	☐	☐
Gnawing	☐	☐	☐	☐
Hot-Burning	☐	☐	☐	☐
Aching	☐	☐	☐	☐
Heavy	☐	☐	☐	☐
Tender	☐	☐	☐	☐
Splitting	☐	☐	☐	☐
Tiring – Exhausting	☐	☐	☐	☐
Sickening	☐	☐	☐	☐
Fearful	☐	☐	☐	☐
Punishing – Cruel	☐	☐	☐	☐

Are you:	☐ Right-handed	☐ Left-handed		
Occupation:				
	☐ Full-time ☐ Part-time	☐ Outside Home ☐ From Home	☐ Unemployed ☐ Retired	☐ Homemaker ☐ Student
Education:	Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 (circle one) ☐ Some college / technical school ☐ College graduate ☐ Graduate school / advanced			
Living Environment:	Does your home have: ☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Elevator ☐ Uneven terrain ☐ Assistive devices (e.g., bathroom) ☐ Obstacles	Do you use: ☐ Cane ☐ Walker or rollator ☐ Manual wheelchair ☐ Motorized wheelchair ☐ Glasses, hearing aides ☐ Other:____________	Where do you live: ☐ Private home ☐ Private apartment ☐ Rented room ☐ Board & care / Assisted ☐ Living / Group home ☐ Long-term care facility (Nursing home) ☐ Other:______________	With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and children ☐ Other relatives ☐ Group setting ☐ Personal care attendant ☐ Other:____________

Functional status / Activity level (check all that apply)

- ☐ Difficulty with movement
  - ☐ Bed mobility
  - ☐ Transfers (moving from bed to chair, from bed to commode)
  - ☐ Gait (walking):
    - ☐ On level ☐ On ramps
    - ☐ On stairs ☐ On uneven terrain
- ☐ Difficulty with self-care (e.g.: bathing, dressing, eating, toileting)
- ☐ Difficulty with home management (e.g.: household chores, shopping, driving/transportation, care of dependents)
- ☐ Difficulty with community and work activities / integration
- ☐ Work / school
- ☐ Recreation or play activity
- ☐ Other: ____

Clinical tests: Within the past year, have you had any of the following tests? (Check all that apply and indicate location of test(s) below.)

☐ Angiogram	☐ Arthroscopy	☐ Biopsy	☐ Blood tests	☐ Bone scan	☐ Bronchoscopy
☐ CT scan	☐ Doppler US	☐ Echocardiogram	☐ EEG	☐ EKG	☐ EMG
☐ Mammogram	☐ MRI	☐ Myelogram	☐ NCV	☐ Pap smear	☐ Pulmonary function test
☐ Spinal tap	☐ Stool tests	☐ Stress test	☐ Urine tests	☐ X-rays	☐ Other: ____________

Location of test(s): ____

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If you are under 18 years of age prior to treatment at this facility, your parent or legal guardian must sign the statement of informed consent below, permitting Kingston Physical Therapy & Sports Rehab., P.C., to provide physical therapy care.

I, ______________________________ , am the parent or legal guardian of ______________________________.

I hereby permit Kingston Physical Therapy & Sports Rehab., P.C., to provide physical therapy to the above-mentioned minor.

Signed: ______________________________ Date: ____________________

KPT Patient Intake Form 10/07