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Great Neck Office: 833 Northern Blvd., Great Neck NY 11021, 516-482-4140
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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	Social Security #: _____	
Address: _____ _____		
Cell Phone: () _____	Home Phone: () _____	E-Mail: _____
Preferred Contact Method: <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> E-Mail		
Referring Physician: _____	Primary Physician: _____	
Employer: _____	Employer Phone: () _____	
Employer Address: _____ _____		
Human Resource Contact Person: _____		

<u>History:</u>
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? <input type="checkbox"/> Yes. <input type="checkbox"/> No. Surgery Date: _____
What medications are you currently taking? _____ _____
What do you hope to gain as a result of physical therapy treatments? (Please check all that apply.)
<input type="checkbox"/> Improved Movement <input type="checkbox"/> Improved Strength <input type="checkbox"/> Decreased Pain <input type="checkbox"/> Improved Posture
<input type="checkbox"/> Improved Endurance <input type="checkbox"/> Increased Work Ability <input type="checkbox"/> Improved Sleep <input type="checkbox"/> Improved Walking
<input type="checkbox"/> Decreased Muscle Spasm <input type="checkbox"/> Improved Balance <input type="checkbox"/> Improved Athletic Performance
<input type="checkbox"/> Other: _____
Do you or a family member have a history of the following? (Check all that apply.)
<input type="checkbox"/> Heart condition <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis
<input type="checkbox"/> Back or Neck Pain <input type="checkbox"/> Leg, Knee, or Foot Pain <input type="checkbox"/> Sprains/Strains <input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Hand/Wrist Pain <input type="checkbox"/> 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? _____

How limited are you with the following activities?

(1= not at all, 2 = slightly, 3 = moderately, 4 = severely, 5 = unable)

Walking _____ Stairs _____ Standing _____ Sitting _____ Transferring Sitting ↔ Standing _____

Bending _____ Lifting _____ Kneeling _____ Squatting _____ Carrying _____ Reaching _____

Dressing _____ Performing Daily Activities _____ Personal Care/Bathing _____ Gripping _____

Pinching _____ Pushing _____ Pulling _____ Holding _____ Writing _____ Driving _____

Housework _____ Yardwork _____ Recreation _____ Sleeping _____ Balance _____

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? _____