Cynergy Physical Therapy

PATIENT INFORMATION

_____ _____ ▫ Male ▫ Female
Last Name First Name

Name of Parent/Guardian if minor
_____

_____
Street Address City
State Zip

_____ _____
_____
Home Phone voicemail Y/N Cellular voicemail Y/N Email Address

_____ _____ ▫ Single ▫ Married ▫ Minor
Social Security Date of Birth

Work Status: ▫ Employed ▫ Retired ▫ Student

_____ _____
_____
Emergency Contact Person Relationship to Person
Phone

_____
_____
Referral Source: (Whom could we thank for referring you to our office?) Phone

_____
_____
Primary Care Physician Phone
Fax: _____

SIGNATURE: _____ DATE:
_____

Cynergy Physical Therapy

Patient/Guardian ----

Relationship to Patient

PRINTED NAME:

_____

PATIENT HISTORY

Name_____ **Age**_____
Date_____

Date of last physical exam _____ Tests performed _____

General Health: ▫ Excellent ▫ Good ▫ Average ▫Fair ▫ Poor

Mental health: Level of Stress: ▫ High ▫ Med ▫ Low Current psych therapy: ▫Yes ▫ No

Activity/Exercise: ▫ None ▫ 1-2 days/week ▫ 3-4 days/week ▫ 5+ days/week

Describe the current problem for your visit today?

_____

_____

____

When did the problem first begin? _____ months ago _____ years ago.

Describe previous
treatment_____

What degree of success have you had with your previous treatment?

_____

_____

____

Have you ever been hospitalized? ▫ Yes ▫ No

If yes, give date and explain

_____

_____

____

Surgical/Procedure History:

_____

Cynergy Physical Therapy

_____
____

Medications:
_____

_____
_____
_____

Allergies: (drugs, chemicals, food)
_____

Are you on disability or applying for disability? ▫ YES ▫ NO

Are you involved in any litigation? ▫ YES ▫ NO

Do you wear: ▫ glasses/contacts ▫ heel lifts ▫ orthotics ▫ dental night guard

What are your treatment goals/concerns?
_____

_____
_

Have you ever had any of the following conditions or diagnoses? Circle all that apply/describe

Cancer	Stress fracture	Latex sensitivity
Heart problems	Multiple sclerosis	Hypothyroid/Hyperthyroid
High Blood Pressure	TMJ problems	Diabetes
Asthma	Epilepsy/seizures	Headaches/Migraines
Tuberculosis	Head injury	Irritable Bowel Syndrome
Ankle swelling	Osteoporosis	Kidney disease
Low back pain	Fibromyalgia	HIV/AIDS
Alcoholism/Drug problems	Chronic fatigue syndrome	Hepatitis A, B, C
Depression	Rheumatoid Arthritis	Physical or Sexual abuse
Anorexia/bulimia	Osteoarthritis	Sexually transmitted disease
Smoking history	Bone fracture	Gallbladder stones
Vision/eye problems	Joint replacement	Stomach or duodenal ulcers
Hearing loss/problems	Neck pain	Persistent/recurrent indigestion
Stroke	Emphysema/Bronchitis	Bowel or intestinal trouble

Cynergy Physical Therapy

Liver trouble or jaundice
Chest pain
Shortness of breath
Birth abnormalities
Insomnia
Snoring
Rupture or hernia
Skin disease/rash
Fainting spells
Paralysis
Contact lenses
Dentures/Bridge
Hemophilia
Recent Infection
Varicose veins
Painful/difficult urination
Anemia

Pregnant/plan to start
Pelvic pain
Crohn's Disease
Pregnancy/Childbirths #
_____
Bipolar disorder
Anxiety
Gout
Pacemaker/Stent/ IUD
GERD
Falls
Chills/Night sweats
Weight loss/gain
Celiac Disease
Deviated Septum
Carpal Tunnel
Sinus Problems

Constipation/Diarrhea
Memory Loss
Diastasis Recti
Incontinence
Endometriosis
Dysmenorrhea
Fibroids/Cysts
Change in Bowel/Bladder
Aneurism
Blood Clots/DVT
Arrhythmia
Food Allergy
Spondylolisthesis
Lupus
Autoimmune Disease

OBGYN History (Female only)
Childbirth vaginal deliveries #___
Episiotomy #_____
C-section #_____
Difficult childbirth ▫ Yes ▫ No
Prolapse ▫ Yes ▫ No
Menstrual cycle: _____ days
Vaginal dryness ▫ Yes ▫ No
Lumps in breast ▫ Yes ▫ No

Painful periods ▫ Yes ▫ No
Menopause when? _____
Painful vaginal penetration ▫ Yes ▫ No
Pelvic pain ▫ Yes ▫ No
Date of last period: _____
Other: _____

Males only:
Prostate disorders: ▫ Yes ▫ No
Pelvic pain ▫ Yes ▫ No

Cynergy Physical Therapy

Erectile dysfunction ▫ Yes ▫ No

Painful ejaculation ▫ Yes ▫ No

Other:

_____

Pain History

Since onset is it staying ▫ same ▫ getting worse ▫ getting better

Activities/events that cause or aggravate your symptoms.

Sitting	Chewing	Triggers such as running water/key in the door
Walking	Swallowing	Being nervous/anxious
Standing	Sleeping	No activity affects the problem
In/out bed or chair	Cough/sneeze/straining	Other, specify
Sexual activity	Laughing/yelling	
Yawning	Lifting/bending	

Type of pain:

Constant	Dull	Shooting throbbing
Piercing	Sharp	Tingling
Aching	Burning	Numbness

Cynergy Physical Therapy

Superficial	Diffused
Deep	Infrequent
Localized	Intermittent

Severity of pain:

None 1 2 3 4 5 6 7 8 9 10 worst

When is your pain or dysfunction the worst?

Morning ▫ During sleep ▫ Afternoon ▫ Upon awakening ▫ Evening ▫

Since the onset of your current symptoms have you had:

Fever/Chills ▫ Yes ▫ NO

Unexplained weight change ▫ Yes ▫ NO

Dizziness or fainting ▫ Yes ▫ NO

Change in bowel or bladder function ▫ Yes ▫ NO

Malaise (unexplained tiredness) ▫ Yes ▫ NO

Unexplained muscle weakness ▫ Yes ▫ NO

Night pain/sweats ▫ Yes ▫ NO

Numbness/Tingling ▫ Yes ▫ NO Other/describe

_____

Head/TMJ History

Does it hurt when you open your mouth wide? ▫ Yes ▫ NO

Does your jaw make noises so that it bothers you or others? ▫ Yes ▫ NO

Do you suffer from pain in face, jaw, eyes, throat, neck, temples? ▫ Yes ▫ NO

Do you suffer from headache? ▫ Yes ▫ NO

Do you grind your teeth in your sleep or has anyone heard you? ▫ Yes ▫ NO

Digestive History

How long have you had abdominal pain?

_____

Do you have more than one pain ▫ Yes ▫ NO

Where is the worst pain located?

_____

How often the pain occur, and how long does it last?

_____

Cynergy Physical Therapy

Does the pain awaken you from sleep? ▫ Yes ▫ NO

Is your pain cramping, aching, burning, knifelike, or…?

_____

Is there anything that alleviate the pain?

_____

Does eating or drinking make pain better or worse? ▫ Yes ▫ NO

Is there any food that trigger pain or diarrhea? ▫ Yes ▫ NO

Describe your bowel movement pattern.(example, one bowel movement every two days, which is hard to pass)

_____

Has this pattern remained constant, or has it changed in recent months?

_____

Is your pain better after a bowel movement? ▫ Yes ▫ NO

Do you have any of the symptoms:

Bloating ▫ Yes ▫ NO Nausea ▫ Yes ▫ NO Vomiting ▫ Yes ▫ NO Belching ▫ Yes ▫ NO Gas ▫ Yes ▫ NO

Have you lost weight in recent month? If so, how much over what period of time? ▫ Yes ▫ NO_____lbs

Have you passed blood in your stool or had black, tarry bowel movements? ▫ Yes ▫ NO

Have you previously been evaluated for these complaints? ▫ Yes ▫ NO

If yes, what tests were performed, and what were results?

_____

Do you smoke? ▫ Yes ▫ NO Do you consume alcohol? ▫ Yes ▫ NO

SIGNATURE: _____ DATE:_____

_____ Relationship to Patient

Cynergy Physical Therapy