SPORTS & MORE
PHYSICAL THERAPY BY ACCESSPT

Name:	Date of Birth:	Referring Provider:
Reason for Therapy:		Occupation:

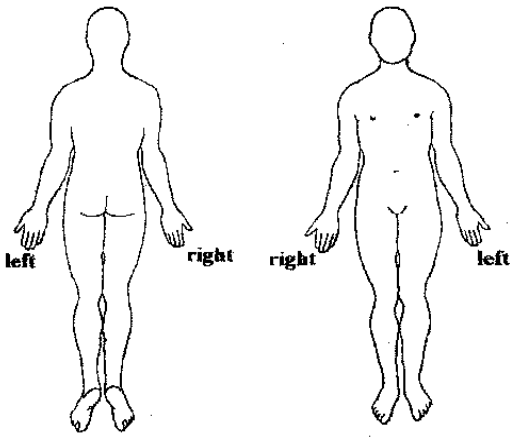
Date the condition began: _____

Is this work-related injury? (Circle One): Yes No

Prior physical therapy? (Circle One): Yes No

Date of next MD appointment for this condition: _____

Please indicate the location of your symptoms on diagram



Current Symptoms

Please indicate your pain intensity at its worst: (Circle One)

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Please indicate your pain intensity at its best: (Circle One)

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Please check the description of your pain (any that apply):

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Burning	☐ Tingling	☐ Stabbing	☐ Shooting
☐ Constant (>75%)	☐ Frequent (50-75%)	☐ Occasional (25-50%)	☐ Intermittent (< 25%)

What increases the pain: _____

What decreases the pain: _____

Please list any Imaging tests performed and the results below:

Past Medical History (Please check all that are applicable):

☐ Abnormal Bleeding	☐ Chronic Back Pain	☐ Diabetes Type II	☐ High Cholesterol	☐ Osteoarthritis
☐ Angina	☐ Chronic Neck Pain	☐ DVT	☐ HIV/AIDS	☐ Osteoporosis
☐ Anxiety	☐ Closed Head Injury	☐ Fibromyalgia	☐ Hypertension	☐ Psoriatic Arthritis
☐ Arrhythmia	☐ Colitis	☐ Frequent UTI	☐ Hypothyroidism	☐ PVD
☐ Asthma	☐ Congestive Heart Failure	☐ GERD	☐ IBS	☐ Rheumatoid Arthritis
☐ Bipolar Disorder	☐ COPD	☐ Glaucoma	☐ Joint Pain	☐ Scoliosis
☐ Blood Clotting Disorder	☐ Crohn's Disease	☐ Gout	☐ Lymphedema	☐ Seizure Disorder
☐ Bowel Incontinence	☐ CVA (Stroke)	☐ Heart Disease	☐ Migraine(s)	☐ Shortness of Breath
☐ Cancer	☐ Degenerative Disc Dx	☐ Hepatitis B	☐ MRSA	☐ Sleep Disorder
☐ Carpal Tunnel Syndrome	☐ Depression	☐ Hepatitis C	☐ Multiple Sclerosis	☐ TB
☐ Cellulitis	☐ Diabetes Type I	☐ Hiatal Hernia	☐ MI/Heart Attack	☐ Urinary Incontinence

Cancer Location(s) and Date(s):	
Surgical/Family/Other Medical Hx:	

Social History

Do you smoke or use smokeless tobacco products?

☐ No, I do not use these products ☐ Yes, I smoke ___ packs per day ☐ Yes, I use smokeless products ___ times per day

Do you drink alcoholic beverages?

☐ No ☐ Yes, If so: How many drinks per day? _____ How many drinks per week? _____

Medications

☐ **Not currently taking any medications** ☐ **Please see attached medication list OR List meds on back page**

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Signature: (Patient/Authorized Representative: (X)_____ **Date:** _____

(Office Use Only) **Therapist Initials:** _____

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Name of Medication	Dosage	Route (by mouth, patch, injection, etc.)