Dr. Steven S. Goldberg, MD - Physical Therapy

Orthopedics and Sports Medicine Rehabilitation

Dr. John A. Ianni, DPT

Patient Information/Health History

Patient Name _____ Date _____

Date of onset, injury, or surgery _____What was your initial treatment? _____

Have you had other treatment for this condition? Yes _____ No _____ If yes, please explain _____

Are you taking any medication now? Yes _____ No_____ If yes please list all medications: **Medications / Dosages**
If you need to, please continue your medications list on the back.

Do you now have, or have you ever had, any of the following:

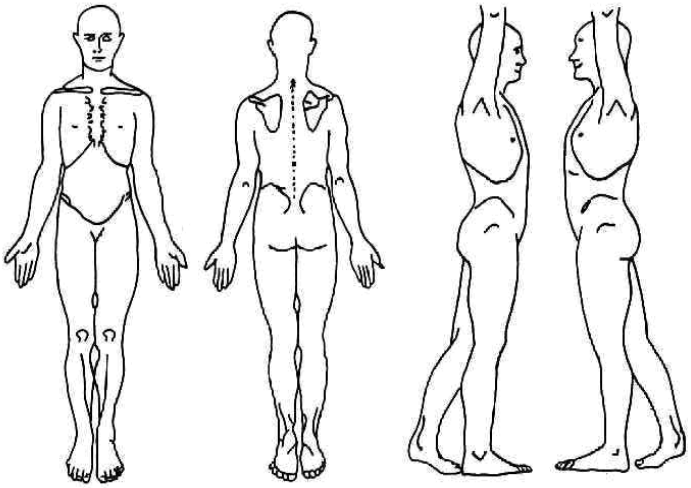
Diabetes	_____	High Blood Pressure	_____	_____
Heart Disease	_____	Stroke/CVA	_____	_____
Pacemaker	_____	Migraine Headaches	_____	_____
Kidney Problems	_____	Rectal Bleeding	_____	_____
Allergies (list below)	_____	Bowel/Bladder Irregularity	_____	_____
Hernia (Ventral, Inguinal, etc.)	_____	Seizures	_____	_____
Metal Implants	_____	Dizziness	_____	_____
Cancer	_____	Pregnant (currently)	_____	_____
Abdominal Pain	_____	Menstrual Irregularity	_____	_____
Muscle Disease / Disorder	_____	Nerve Disease / Disorder	_____	_____

Previous Surgeries (list year & type): _____

Any other medical conditions the Physical Therapist should be aware of?: _____

If **yes** to any of the above, please explain further **below** (and continue on back if needed) and give approximate dates:

Place a Small <u>CIRCLE</u> (or dot) where you feel the pain.
Please <u>SHADE</u> any areas the pain radieates to.



Briefly describe your current resting pain (circle all that apply)

constant intermittent sharp dull achy burning

Pain Intensity: Please Circle current level of pain

At **REST**: 0 1 2 3 4 5 6 7 8 9 10
No pain mod pain worst pain

At **BEST**: 0 1 2 3 4 5 6 7 8 9 10
No pain mod pain worst pain

At **WORST**: 0 1 2 3 4 5 6 7 8 9 10
No pain mod pain worst pain

Any futher description / explanation of pain (continue below or on back): _____

SEE THE BACK TO FINISH

I certify to the best of my knowledge, the information provided thus far is correct.

I understand I will be provided an opportunity to discuss this further with the Doctor of Physical Therapy, and will be provided with a description of my individualized Physical Therapy treatment plan that will be used and rendered to meet your goals. It will include the potential benefits and any associated risks of Physical Therapy, and failing to complete Physical Therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my Physical Therapy treatment plan. I have read and understand the information above, and agree to consent to Physical Therapy treatment to be provided by Liscensed Doctors of Physical Therapy (DPT) and/or there Physical Therapy Assistants (PTA) here at Dr. Steven S. Goldberg's Office.

Signature: _____ **Date:** _____

□ Patient (self) □ Legal guardian □ Power of attorney