

<p>Thank you for choosing <i>Sylva NC PT</i></p> <p><i>Please tell us about yourself using this confidential form.</i></p> <p>sylvancpt@gmail.com 828-506-1157 SylvaNCPT.com</p>	Pt # _____ Date _____
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Preferred name _____ Pronouns _____ Legal name _____
 (If under 18) Parent/Guardian name _____
 Address _____ Email _____
 Phone _____ Date of birth _____ Age ____ Approx ht _____ Approx weight _____
 Gender identity _____ Sexuality _____ Relationship status _____
 Primary care provider _____ How did you hear about Sae Smyrl or Sylva NC PT? _____
 Preferred way to receive brief messages such as appointment reminder (circle): Text Email Phone
 Please confirm or question these appointments, so we're on the same page.

Other types of treatments you receive (circle): chiropractic massage acupuncture other _____
 General health status (circle): excellent good fair poor
 List current meds (or bring a list to copy) _____
 Taking any blood thinning or anticoagulant medications? _____ NSAIDs? _____ Latex sensitive? _____
 Are you pregnant or think you might be? _____ Do you smoke? _____ Consume alcohol? _____ drinks/wk.
 Do you exercise? _____ How? _____ Intensity level? _____ How many times per week? _____
 Would you like help with general exercise/fitness? If so, goals? _____
 Occupation/hours _____

Important Medical History

Please check and circle any conditions which you have had or are currently having and provide details if needed.

- Angina/Chest Pain Asthma
- Arthritis (osteo/rheumatoid/other _____)
- Blackouts
- Blindness
- Blood Clots
- Bowel or Bladder Problems (incontinence/leaking OR constipation/difficulty urinating)
- Carpal Tunnel Syndrome (left OR right)
- Chest/Abdominal Surgery
- Coronary Artery Disease
- Cancer (type), treatments _____
- Chemical dependence
- Concussion OR brain injury
- Depression/Anxiety/Panic attacks/other _____
- Diabetes (requiring medication or insulin injections?)
- Diverticulitis
- Ear Infections
- Endometriosis
- Fibroids
- Fibromyalgia
- Fractures _____
- Frequent Falls (fallen in the last 3 months?) _____
- Hearing Problems
- Heart Disease/heart attack/cardiac surgery? pacemaker/defibrillator?
- Hepatitis/liver problems
- High Blood Pressure
- High Cholesterol
- HIV-AIDS
- Hypoglycemia/low blood sugar/passing out
- IMPLANTS of any type _____
- Lung disease or difficulty breathing (asthma/emphysema/COPD)

- Menopause or Perimenopause
- Migraine (Headaches or other symptoms: VERY sensitive to light/sound/smells)
- Osteoporosis/osteopenia (losing bone density)
- Spinal Injury/surgery _____
- Polio/MS/neurologic disorders
- Seizure. When was the most recent one? _____
- Stroke/TIA _____
- Traumatic Injury, auto, motorcycle, work, sporting accident _____
- Vertigo/Spinning/light headedness _____
- Any other Injuries and surgeries, and approx dates _____

Any other trauma you would like your PT to be aware of _____

****What is your primary concern and reason for seeking physical therapy today?** _____

When did this start? _____ ****What is this preventing you from doing that is important to you?**

Had any **tests** for this condition? _____ What type? (circle) X RAY MRI CT injection blood work Results? _____

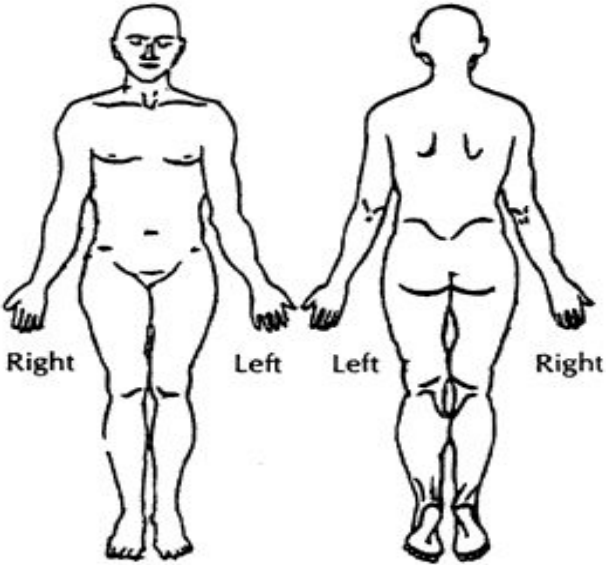
Have you had any **treatment** for this condition, if so, results? _____

Are symptoms getting worse, better, or same? _____ What do you think is contributing to this problem?

Personal goals for PT _____

PAIN: (from 0 to 10) Rate your current level of pain _____. In the past 3 days: Lowest _____. Highest _____. (Circle) Constant or occasional?

Indicate how/where on the body chart. **X** sharp. **O** Dull/ache. **///** Throbbing. **++** Burning **::** Numb/tingling?

	<p>What makes it worse?</p> <p>What makes it better?</p>
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Consent:

1. I agree to receive evaluation, treatment and education on my first appointment.

Patient or Parent/Guardian Signature _____ Date _____

2. I give permission to share results of this evaluation or other treatment records with my healthcare provider(s) _____, if requested.

Patient or Parent/Guardian Signature _____ Date _____