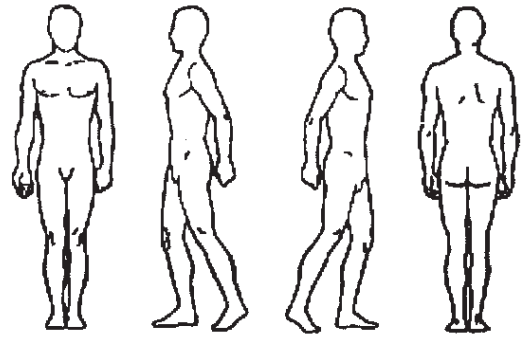
INJURY / CONDITION INFORMATION CONT.

Please draw your painful areas on the body diagram



Please rate your pain on a scale from 0 (no pain) to 10 (worst pain)

Your pain currently	0	1	2	3	4	5	6	7	8	9	10
Least amount of pain since injury	0	1	2	3	4	5	6	7	8	9	10
Most amount of pain since injury	0	1	2	3	4	5	6	7	8	9	10

Is your pain affecting your ability to sleep? Y N

Does the time of day affect you symptoms? Y N

Does coughing/sneezing affect your symptoms? Y N

What makes your symptoms BETTER? _____

What makes your symptoms WORSE? _____

What do you hope to gain from physical therapy? _____

_____

MEDICAL HISTORY

I CURRENTLY have or have had a HISTORY of: (please circle all that apply)

Y	N	High Blood Pressure	Y	N	Currently Pregnant	Y	N	Allergies
Y	N	Heart Trouble/Angia	Y	N	Seizures	Y	N	Metal Implants
Y	N	Pace Maker	Y	N	Osteoporosis	Y	N	Sensitive to Ice/Heat
Y	N	Diabetic	Y	N	Headaches	Y	N	Vision Problems
Y	N	Smoking/Tobacco Use	Y	N	Dizziness	Y	N	Hearing Problems
Y	N	Cancer/Tumor	Y	N	Asthma/Short of Breath	Y	N	Major Injury to Neck/Spine/Back
Y	N	Severe Night Pain	Y	N	Kidney Problems	Y	N	Black Outs
Y	N	Bowel/Bladder Problems	Y	N	Nervous Disorder	Y	N	Bruising Easily

Please check CURRENT MEDICATIONS used:

- ☐ Steroids (cortisone)
- ☐ Heart Medication
- ☐ Muscle Relaxants
- ☐ Anti-Inflammatory
- ☐ Blood Pressure Medication
- ☐ Insulin (diabetes)
- ☐ Pain Killers
- ☐ Anti-coagulants (blood thinners)
- ☐ Other _____

Please list PREVIOUS SURGERIES and their dates:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

☐ PLEASE CHECK THIS BOX IF YOU HAVE HIV OR HEPATITIS

PATIENT AUTHORIZATION **(PARENT CONSENT IS NEEDED IF PATIENT IS UNDER THE AGE OF 18)**

I hereby authorize my consent as a Parent / Guardian of : _____ **for physical therapy evaluation and treatments rendered by Glinn & Giordano Physical Therapy, Inc.** (signature) _____.

The undersigned authorizes Glinn & Giordano Physical Therapy, Inc. to release medical information as requested by insurance companies, employers and other responsible parties, unless otherwise directed. In the event authorization to release information is denied, payment for all services must be made at the time of service. I understand that any co-payment or share of cost will be charged and I am responsible for payment of all co-payments, share of costs or deductibles.

I also authorize payment of medical benefits from my insurance company or third party payer to Glinn & Giordano Physical Therapy, Inc.

I give Glinn & Giordano Physical Therapy, Inc. my consent to perform physical therapy services according to the recommended plan of treatment provided by my therapist.

Responsible Party (signature): _____

Responsible Party (address): _____

Patient Name (please print): _____

Patient Signature: _____ Date: _____