ADVANCED PHYSICAL THERAPY, P.C.
NEW PATIENT INFORMATION

Your dominant side? ○ Left ○ Right
Your injured side? ○ Left ○ Right

Description of Problem: _____
How did you injure yourself? _____
When did your problem start (please give date)? ___/___/___
What activities give you the most trouble/pain? _____
Do you have any allergies? If yes, please list: _____
Are you currently taking medications? If yes, please list: _____

Do you have active Tuberculosis? ○ Yes ○ No
Have you been exposed to active Tuberculosis? ○ Yes ○ No

Do you have any of the following conditions?

	○ Bone Disease	○ Bleeding Disorder
○ Diabetes	○ Cancer	○ Heart Condition
○ Asthma	○ Heat/Cold Reaction	○ Pacemaker
○ History of Polio	○ Seizures/Epilepsy	○ Stroke
○ Fibromyalgia	○ Pregnant	○ Other
○ Smoker	○ Hypertension	○ None of the Above

○ Connective Tissue Disease/Rheumatoid Arthritis

Current Employer: _____
Job Title: _____
Starting date with current employer: ___/___/___

Work Requirements:	Is Your Job:	Work Status:
○ Sedentary	○ Skilled	○ Light
○ Light	○ Unskilled	○ Full
○ Medium		○ Overtime
○ Medium/Heavy		○ Not Working
○ Heavy		

If you answered "Light or Not Working" under Work Status, please answer below:
Beginning Date of Restrictions: ___/___/___

Is this a Workers' Compensation Case? ○ Yes ○ No

Patient Goals: ○ Return to Work ○ Return to Daily Activities ○ Decrease Pain ○ Other

PATIENT NAME: _____
Date of Birth: _____