Blackstone Valley Physical Therapy Services, Inc.
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Medical History and Present Condition

Name: _____ Age: _____ Gender: M F Height:_____ Weight:_____

Have you received any X-rays or MRI related to your injury? No____ Yes :(when) _____

Have you had any surgeries in the past? No____ If yes, please specify the procedure and date (approximate date for older procedures): _____

Have you had physical therapy in the past year? No____ If yes, please note where, when, for what, and approximately how many visits:_____

Do you have any allergies we should be aware of? No____ If yes, please specify: _____
_____

What is the date of your next physician visit? _____

What is your current exercise program? _____
_____

Please check if you or a family member has experienced any of the following conditions:

Medical History/Condition	Patient	Family	**Medical History/Condition**	Patient	Family
Anxiety/Depression			Heart Attack/Surgery		
Asthma/Hay Fever			Immune Deficiency/Disease		
Arthritis			Recent Infection		
Back injury or pain			Joint Replacement Surgery		
Cancer/Tumor			Kidney Disease		
Chest Pain			Liver Disease/Hepatitis		
Clotting/Bleeding Disorder/DVT			Lung Disease/COPD/Tuberculosis		
Concussion or Brain Injury			Osteoporosis		
Convulsions/Epilepsy			Neck Injury or pain		
Diabetes			Neurological Disease/Stroke		
Vision Issues/Glaucoma/Cataracts			Pace Maker/Defibrillator		
Fractures			Skin Disorders/Psoriasis		
Fever/Chills/Sweats			Are you a Smoker?		
Fibromyalgia			Thyroid Disease		
Headaches			Unexplained weight changes		
High Blood Pressure/Hypertension			Vertigo/Vestibular Issues		
High Cholesterol/Hypercholesterolemia			Could you be pregnant?		

Are there any other conditions we should be aware of?:_____

Please complete both sides.

WHEN did your current complaint (pain/symptoms) begin?: _____
HOW did it start?_____

What makes the pain/symptoms increase? □ Work □ Sports □ Standing □ Sitting
□ Lying Down □ Housework □ Yardwork □ Lifting □ Reaching □ Dressing
□ Other(s): _____

What makes the pain/symptoms decrease? □ Rest □ Heat □ Standing □ Sitting
□ Lying Down □ Medications □ Sleeping □ Ice □ Exercise □ Stretching
□ Other(s): _____

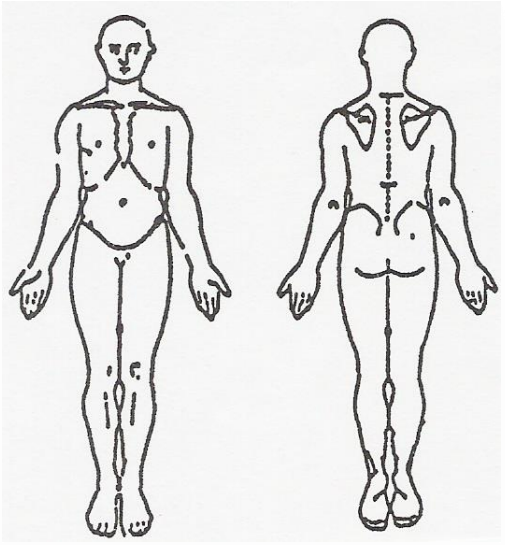
How often do you have the symptoms? □ Constantly □ Occasionally □ Rarely
□ Only when I _____

Are the symptoms? □ Improving □ Worsening □ Remaining the same

Because of my current complaint I am having difficulty with:_____

_____

Please shade areas of your symptoms below



What would you rate the pain/symptom level:

At worst, when I _____, the pain is a:
0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

Currently, sitting here, the pain level :
0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

At best, when I _____, the pain is a:
0 1 2 3 4 5 6 7 8 9 10
No pain Minor Moderate Severe Worst pain ever

What are your current goals for physical therapy?

_____

How did you hear about us? Please check all that apply :
□ Medical referral □ Internet search □ Uxbridge Times □ Golf Advertisement
□ Social Media □ Website □ Other_____
□ Sports sponsorship □ Insurance referral □ Friend/Family referral (whom should we thank):
□ Wellness programming (MRA, classes, etc) _____

We can use video for educational, demonstration, and marketing/promotional purposes. We don't require anyone to be recorded, and we will discuss any recording/photographing prior to bringing a camera or other device out. We can use your device as well, if you prefer.

By initialing, I give my written consent to be photographed/videotaped during my treatment for:
_____ My own therapeutic use only (any picture or video will be deleted after review)
_____ I would prefer my own device be used
_____ BVPTS Marketing/Promotional Materials (Website/Social Media/Advertising)