

New Patient/ New Problem

Patient Name: \_\_\_\_\_

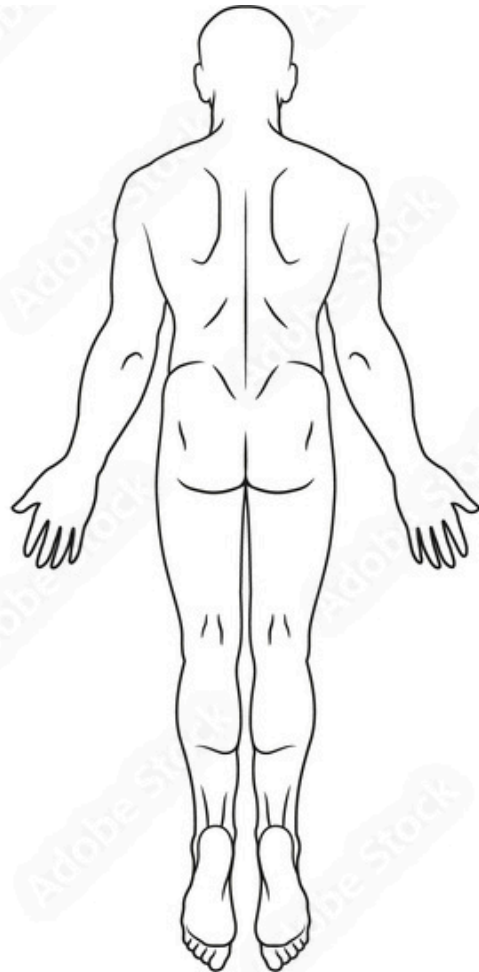
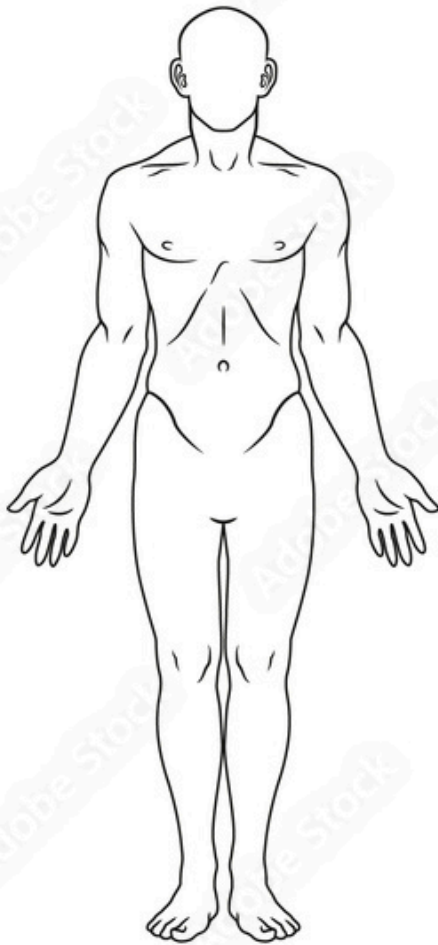
Date of Birth: \_\_\_\_\_

What date or approximate date did symptoms start? \_\_\_\_\_

Injury/Trauma? \_\_\_\_\_

Location of pain (Circle/Mark)

Which side? Left Right Both



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Please list what sports and/or other physical exercise you do: \_\_\_\_\_

\_\_\_\_\_

How many hours per week? \_\_\_\_\_

What days of the week? \_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

Prior treatment (Please list the date and specific type of surgeries or injections): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had Physical Therapy?      Yes \_\_\_      No \_\_\_

If yes, how many sessions/ times per week: \_\_\_\_\_

Which Physical Therapy Facility? \_\_\_\_\_

What treatments helped? \_\_\_\_\_

Prior imaging (Circle/Mark)      X-Ray      MRI      CT      Ultrasound

Date of Imaging (approx): \_\_\_\_\_      Facility: \_\_\_\_\_

Tried and/or failed medications for this problem: \_\_\_\_\_

\_\_\_\_\_

Referring Provider: \_\_\_\_\_

Please bring your imaging on a CD along with the report to your visit.