PERfect FORMation PT

PATIENT CURRENT INJURY FORM

Patient Information:

Patient Name: _____ Age: _____

Occupation: _____

Recreational Activities: _____

Primary Care Physician: _____ Phone : (_____) _____-_____

Current Condition:

Area of Injury: _____

Date the injury began: _____/_____/_____

What made it begin: _____

_____

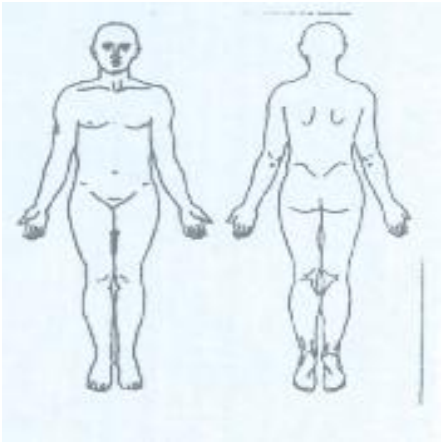
Circle the activities below which increase discomfort:

walking sitting standing climbing stairs

jumping reaching lying down sleeping

Circle the number indicating the most pain you have in a day in this area: 1 2 3 4 5 6 7 8 9 10

Please shade area of pain:



Past Medical History:

Have you ever received physical therapy before? Yes No

If yes, for what condition and when. _____

Please list all surgeries you have undergone and when _____

_____

Please circle any that apply to you:

Heart Condition	Chest Pains	High Cholesterol	Breathing Condition
Diabetes	Past Heart Attack	Seizures	Pregnancy
Smoker	High Blood Pressure	Allergies	Cancer

Others:_____

Consent to Treat

The information submitted on this form is to the best of my knowledge. I understand and am aware of the risks pertaining to the treatment of physical therapy. I acknowledge the roles of the care my physician and physical therapist are in my care and will follow their suggestions as best I can. I have the right to ask for a more in depth understanding of a treatment technique at any time and if I do not feel comfortable with the technique refuse treatment at any time.

Signature: _____ Date: _____

If patient is a minor, authorization to treat patient.

Signature of Guardian: _____ Date: _____