UXBRIDGE
Orthopedic & Sports Therapy

Name:_____ Date of Birth: _____

Height:_____ Weight:_____

Current area of injury/problem: _____

Date of Injury/surgery:_____

Please list current tests/procedures for your current problem and dates (MRI, XRAY, etc):

_____

_____

Please describe and rate your pain (0= none and 10= extreme) and its location: _____

What makes your pain worse? _____

What makes your pain better? _____

Occupation:_____ Hours per week worked: _____

Job Responsibilities: (circle) lift, pull, push, prolonged sitting, prolonged standing, heavy lifting, overhead reaching, other : _____

Social/Living Environment: Do you live alone? YES/ NO
If no, who lives with you? _____

Type of dwelling: (circle) Condo/Apt/ House/ Other: _____

Stairs: YES/ NO Rail(s): YES/NO/BOTH

Have you fallen in the past year? YES/ NO if yes, how many times: _____
Is your MD aware of this YES/NO

ALLERGIES:_____

CURRENT MEDICINE LIST (can also provide copy):

Medications	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Please check off all that apply

❑ Arthritis/swollen joints/gout	❑ Depression /Anxiety (circle)
❑ Asthma, Bronchitis, Emphysema/COPD	❑ Alcohol/Drug Dependency
❑ Stroke/TIA date: _____	❑ Migraine headaches
❑ Coronary Heart Disease/Angina/Chest pain	❑ Osteoporosis/osteopenia
❑ Family history of cardiac disease	❑ Tendonitis/Bursitis
❑ Bypass Surgery date: _____	❑ Hemophilia
❑ Cardiac pacemaker/defibrillator	❑ Hernia
❑ Blood clot/emboli	❑ Liver disease
❑ High Blood Pressure	❑ Kidney Disease ❑ on Dialysis YES NO
❑ Low Blood Pressure	❑ Thyroid problems
❑ Family history of cancer	❑ Lupus/Fibromyalgia/Autoimmune disease
❑ Cancer Site	❑ Herpes
❑ Chemo/radiation	❑ Neurologic disorders
❑ Epilepsy/ most recent seizure date_____	❑ Bone Fractures where: _____
❑ Nausea/ Vomiting	❑ Pregnant
❑ Bowel/ Bladder problems	❑ Circulation difficulties: _____
❑ History of Aneurysms	❑ Tuberculosis
❑ Any pins/ metal implants	❑ Smoking: Packs/day _____
❑ Diabetes	❑ History of falls
❑ Ulcer/Stomach Issues	❑ Numbness/tingling
❑ Dizziness or fainting	❑ Weight loss/Energy loss

Other/ or Please explain any checked:

_____
_____
_____
_____

What is your goal with Physical Therapy?

Form Completed By: _____ Date: _____

Reviewed by Therapist: _____ Date: _____