SYNERGY
PHYSICAL THERAPY & SPORTS MEDICINE

Personal Information

Name: _____Birth Date:_____SS #_____

Address: _____City/ State/ Zip Code:_____

Phone:_____ E-mail: _____

Parent/Emergency Contact Name: _____ Relationship: _____

Parent/Emergency Contact Phone: _____ Birth Date: _____SS #_____

WORKER'S COMPENSATION ONLY:
Case Manager/Claim Adjuster: _____ *Phone:*_____

How did you hear about us? ☐ Web Search ☐ Friends/Family ☐ Physician Referral ☐ Social Media ☐ Advertisement

History

Do you exercise? ☐ Yes ☐ No If yes, how often? _____

Do you smoke? ☐ Yes ☐ No If yes, how often? _____

Allergies: _____

List all medications you are currently using: (We can make a copy if you have a list.) _____

_____

Previous surgeries (Related to current complaint): _____

Have you had physical therapy in the last calendar year? _____ If so, where?_____

Complaint

What is your major complaint? _____

Surgery Date/Symptoms Began: _____ Possible Cause: _____

Previous treatment for complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They are Worst: _____

Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions

Level of Pain: **0 (No pain) - 10 (Very severe) Scale** Current: _____ Best:_____ Worst:_____

Is your pain getting better or worse?_____ Have you had this injury before?_____

Referring Physician: _____ Physician Follow-Up Date: _____

Do You Have Any of the Following Today? (Check All That Apply)

☐ Stroke	☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Parkinson's	☐ Asthma
☐ Arthritis	☐ Blood Clots	☐ Cancer _____	☐ Circulation Problems	☐ Depression	☐ Diabetes
☐ Lung Issues	☐ Heart Problems	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Multiple Sclerosis	
		☐ Musculoskeletal Problems	☐ Rheumatoid Arthritis		