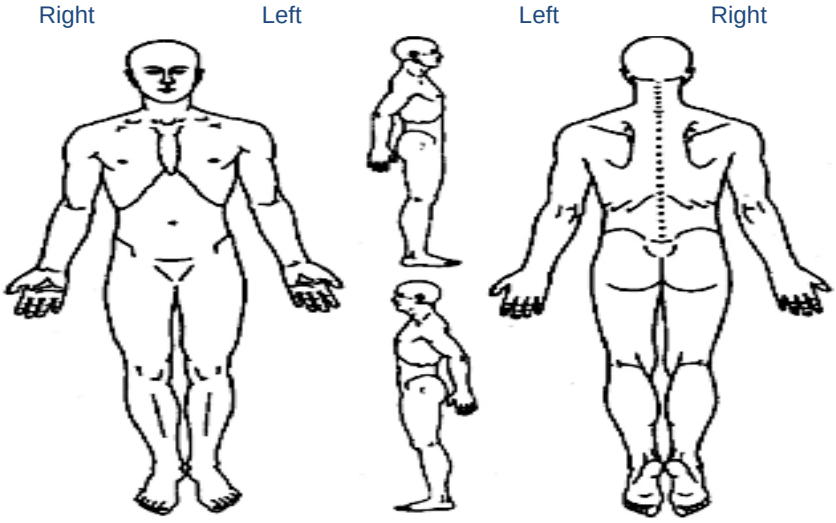
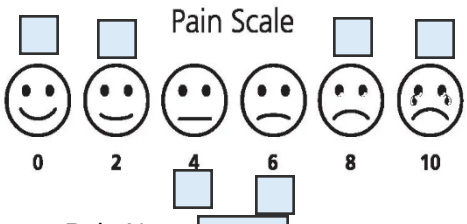
Momentum Physical Therapy

Name: _____

Please place an (X) where you are experiencing discomfort.





Pain Now: _____

Pain At Best: _____

Pain At Worst: _____

Please briefly describe the injury you are being seen for today:

Please list all surgeries:

Please list any allergies:

Please list all current medications (if any):

Have you been diagnosed with any of the following conditions? (check all that apply)

Allergies	Diabetes	Metal implants
Anemia	Dizziness/vertigo	Multiple sclerosis
Anxiety	Emphysema/Bronchitis	Neurological disorder
Arthritis	Fibromyalgia/Chronic fatigue	Numbness/tingling
Asthma	Fractures	Osteoporosis/Osteopenia
Bladder/Bowel problems	Gastrointestinal problems	Pain syndrome/CRPS
Cancer	Gallbladder/Kidney problems	Parkinson's
Cardiac disease/conditions	Headache/Migraines	Seizures
Pacemaker/defibrillator	Hepatitis	Speech problems
Circulation problems	Hernia	Strokes
Currently pregnant	High blood pressure	Thyroid problems
Depression	Incontinence	Vision problems

Use of **Electrodes** may be necessary in your treatment and are not covered by insurance. Personal electrodes may be purchased for $5.00 or general electrodes are available in the office at no cost to you.

Please indicate: Personal electrodes OR General electrodes

Use of **TheraBands** may be necessary in your treatment for exercises to be completed at home and are not covered by insurance. The cost for TheraBand is $5.00 (one-time fee) and is due when issued.

Patient Signature: _____ **Date:** _____

(Parent or Guardian if patient is a minor)