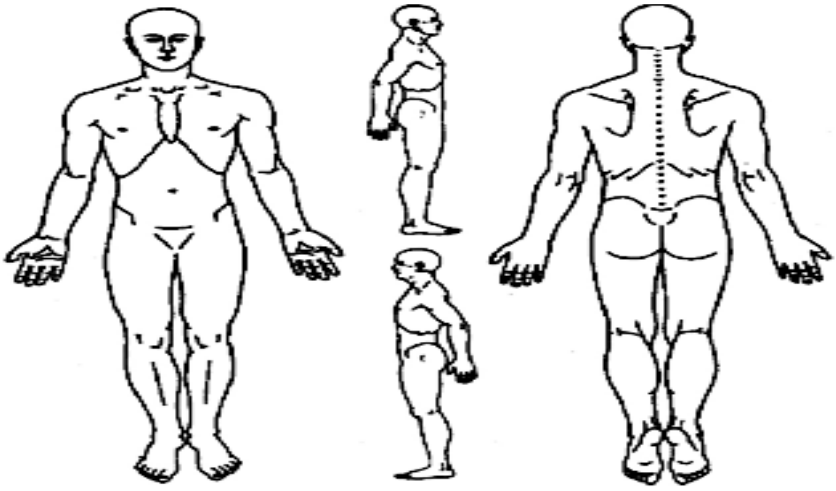
Momentum Physical Therapy

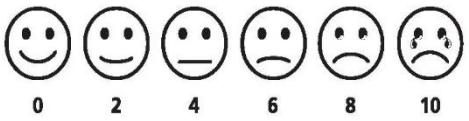
Name: _____

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

Right Left Left Right



Pain Scale



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)