60 S. Washington St. Greencastle PA, 17225
Phone: 717-643-0574

Name: ______________________ Date of Birth: ______________________

Address: ____
Street / City / State / Zip

Email: ______________________ SSN: ______________________

Primary Phone #: ______________________ ☐ Home ☐ Cell ☐ Work

Secondary Phone #: ______________________ ☐ Home ☐ Cell ☐ Work

Marital Status: ______________ Leisure Activities: ______________________

Occupation: ______________________ Handedness: ☐ Left ☐ Right

Emergency Contact: ______________________ Phone #: ______________

Relationship to Patient: ____

Who is your primary care physician? ____

What is the name of the physician who referred you to physical therapy if different from above?

____

Is this a motor vehicle related injury? ☐ Yes ☐ No Is this a work-related injury? ☐ Yes ☐ No

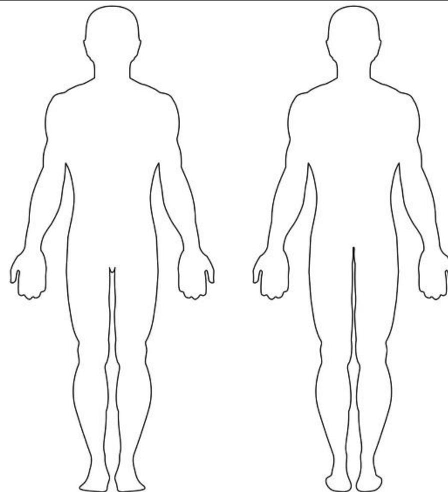
Females: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Allergies List any medication(s) you are allergic to: ____

Are you latex sensitive (allergic to latex)? ☐Yes ☐No

List any other allergies we should know about: ____

Please mark all the locations on the body diagram where you have pain or other symptoms with an **X**



Current medications (Including pills, injections, and/or skin patches) ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Previous Hospitalizations	Date
___	___
___	___
___	___
___	___
___	___

Previous Surgeries	Date
___	___
___	___
___	___
___	___
___	___

During the past month have you been feeling down, depressed, or hopeless? Yes No
During the past month have you been bothered by having little interest or pleasure in doing things? Yes No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Please list all dates and test names of any diagnostic testing you have had in the past 3 months (bloodwork, x-rays, MRI, etc)..
___ ___ ___

Have you fallen in the past 12 months? Yes No If YES, please describe any injury you obtained from that fall: ___

Please check (✓) any of the following whose care you're currently under…

__ Medical Doctor (MD) __ Osteopathic Doctor (DO) __ Dentist __ Psychiatrist/Psychologist __ Physical Therapist __ Chiropractor
__ Athletic Trainor __ Nurse Practitioner __ Physician Assistant __ Other:___

If you have been seen by any of the above during the past 3 months, please describe for what reason (illness, medical condition, physical exam, etc…): ___

How much cups of caffeinated beverages do you drink per day? ___ How many cigarettes do you smoke per day? ___
If one drink equals one beer or glass of wine, how muck do you drink at an average sitting? ___
How often do you drink alcohol? ___ How often do you use marijuana or other illegal drugs? ___

Please circle any and all conditions **YOU** have been diagnosed with:

Heart Problems	High Blood Pressure	Asthma/Emphysema	Tuberculosis
Chemical dependency	Thyroid Problems	Diabetes	Stroke
Multiple Sclerosis	Rheumatoid Arthritis	Osteoarthritis	Anemia
Depression	Hepatitis (Type) ___	Kidney Disease	Epilepsy
Headaches	Cancer (Type)___	History of Bloodclots/DVT	

Other ___

Please circle any of the following that are new, unusual, or atypical for you: **(Currently experiencing)**

Weight Loss/Weight Gain	Nausea/Vomiting	Fatigue	Weakness	Easy Bruising
Dizziness/Lightheadedness	Fever/Chills/Sweats	Numbness/Tingling	Tremors	Difficulty Breathing
Double Vision/Loss of Vision	Seizures	Eye Redness	Skin Rash	Regular Cough
Problems Sleeping	Sexual Difficulties	Night Sweats	Hearing Problems	Excessive Bleeding
Recently Fallen Down	Joint/Muscle Swelling	Arm/Leg Swelling	Heart Racing in Chest	Blood In Stools
Difficulty Swallowing	Heartburn/Indigestion	Constipation/Diarrhea	Post-Menopause	Problems Urinating
Blood in Urine	Stress @ Home/Work	Problems with Balance		