

Injury Information

Circle which applies to your symptoms:

Work Related Injury Athletic Injury Motor Vehicle Accident

Related to a Previous Injury Other _____

Are you presently working? _____ What is your occupation? _____

Date of Injury / Onset _____ Date of Surgery _____

Date of next doctor's visit _____

Have you ever had these symptoms before? _____

Please check any of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Aspirin |
| <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> Allergies to Heat |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies to Cold |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness / Fainting |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Recent Fractures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Bowel / Bladder Abnormalities | <input type="checkbox"/> Skin Abnormalities |
| <input type="checkbox"/> Liver / Gall Bladder Abnormalities | <input type="checkbox"/> Ringing in your Ears |
| <input type="checkbox"/> Asthma / Breathing Difficulties | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Special Diet Guidelines |

Is there any information in your past medical history that we should know about?

Are you presently taking any medication? _____ If yes, please list medications:

Rate the intensity of your pain on a scale of 0 to 10, with 10 being the worst pain possible (circle one).

0 1 2 3 4 5 6 7 8 9 10

In case of emergency, contact: _____

Phone# _____

The services of a social worker are available through Atlantic Physical Therapy Center. Please indicate if you feel the need for such services. _____

I hereby authorize Atlantic Physical Therapy Center through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures related to my condition.

Patient Signature _____