W. JEFF JONES
PT, MPT, OCS, COMT, CERT. DN

R3PT
Rehab. Repair. Restore.

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Patient Information

Patient Name: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Occupaton: _____ **Who Recommended our Services?:** _____

History of Current Condition

Location of Current Condition (Body Part Involved): 1: _____

2: _____

Date of Initial Injury or Onset of Symptoms For This Current Condition:

_____

Briefly Describe This Current Problem or Condition:

_____

PT NOTES

Have There Been Subsequent Injuries or Flare-ups? ___ Yes ___ No If "Yes", Describe:

_____

Do You Have Previous History of This Same Problem, or a Similar Condition? ____ Yes ___ No If "Yes", Describe:

_____

PT NOTES

Medical Consultations for this Condition: Who Is Your Referring Doctor?

_____

Other Physician Consults? 1. _____ **2.** _____

Diagnostic Tests for this Condition: ___ **Xrays** **Results:** **Normal** ___ **Findings** _____

PT NOTES

___ **MRI** **Results:** **Normal** ___ **Findings** _____

___ **Bone Scan** **Results:** **Normal** ___ **Findings** _____

___ **EMG/NCV** **Results:** **Normal** ___ **Findings** _____

___ **CT SCAN** **Results:** **Normal** ___ **Findings** _____

___ **Other** _____ **Findings** _____

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Surgeries for this Condition? ____ **Yes** ____ **No** **if Yes, Please Describe Below:**

Prodedure: _____ **Date:** _____ **Surgeon:** _____ **City:** _____

Prodedure: _____ **Date:** _____ **Surgeon:** _____ **City:** _____

Prodedure: _____ **Date:** _____ **Surgeon:** _____ **City:** _____

Physical Therapy for this Condition: ___ **Yes** ___**No** **Describe:** _____

Other Consults for this Condition: ___ **Yes**___**No** **Describe:** _____

PT NOTES

History of Previous Other Orthopedic Problems

Please List Other Orthopedic Injuries or Conditions for Which You Have Been Treated:

Injury: _____ **Surgery:** _____ **Surgeon:** _____

Year: _____ **Physical Therapy:** _____ **Where:** _____

Injury: _____ **Surgery:** _____ **Surgeon:** _____

Year: _____ **Physical Therapy:** _____ **Where:** _____

PT NOTES

Previous Conditions Requiring Hospitalization: _____

Previous Surgeries (non-orthopedic): _____

Allergies: _____

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Do You Have Any Current or Past History Of:

☐ High Blood Press.	__Current __Past	☐ Heart Conditions	__Current __Past	☐ Diabetes	__Current __Past
☐ Stroke	__Current __Past	☐ Circulatory Probs	__Current __Past	☐ Pacemaker	__Current __Past
☐ Seizures/Epilepsy	__Current __Past	☐ AIDS/HIV+	__Current __Past	☐ Cancer	__Current __Past
☐ Osteoporosis	__Current __Past	☐ G.I. Problems	__Current __Past	☐ Migraines	__Current __Past
☐ Kidney Disease	__Current __Past	☐ Liver Disease	__Current __Past	☐ Smoking	__Current __Past
☐ Dizziness/Vertigo	__Current __Past	☐ Asthma	__Current __Past	☐ Arthritis	__Current __Past
☐ Neurologic Prob.	__Current __Past	☐ Metal Implants	__Current __Past	☐ Alcoholism	__Current __Past
☐ Varicose Veins	__Current __Past	☐ Lung Disease	__Current __Past	☐ Other	__Current __Past

PT NOTES

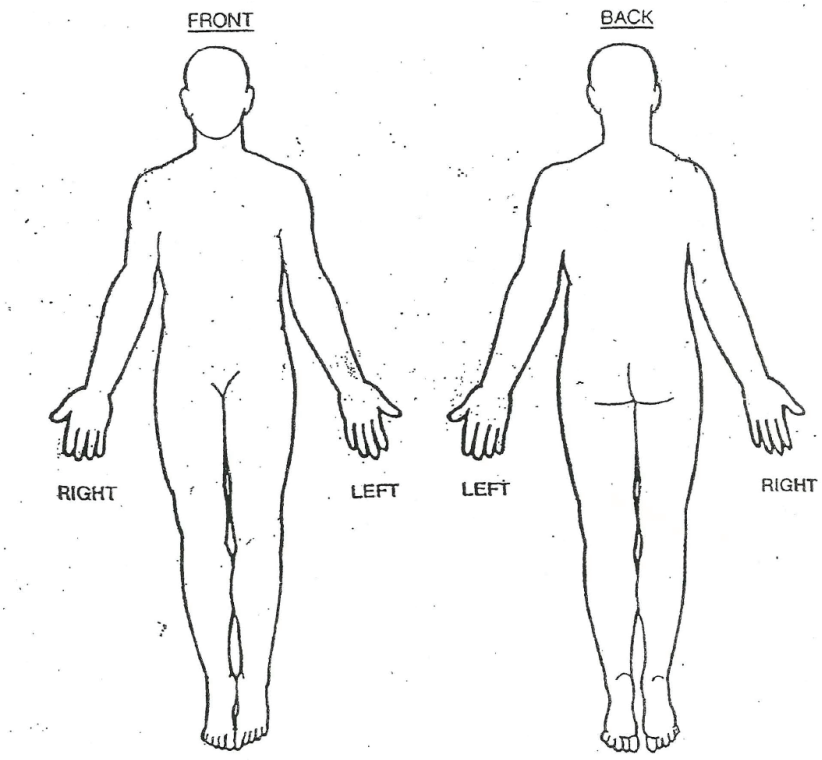
Please Indicate the following:
Type of symptoms you are experiencing (i.e. burning aching, sharp, dull, etc) _____

Percentage of symptoms that occur in your: trunk (neck/back) ____ **arms/legs** _____

Please check one of the following: Symptoms are _____ **constant** ____ **intermittent**

If intermittent, percentage of the day in which symptoms are present: _____

Draw the location of the symptoms in the body outlines below



Please mark the intensity of your pain below

No Pain (0/10) **Intolerable Pain (10/10)**

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List Current Medications: _____ **For:** _____

_____ **For:** _____

_____ **For:** _____

Is there any chance you are currently pregnant? **Yes** __ **No** ___ **Detail** _____

PT NOTES

ACTIVITIES: WORK, SPORTS, EXCERCISE/TRAINING

Describe Your Regular Sports Activity & Frequency: ☐ **Golf** _____ ☐ **Tennis** _____

☐ **Basketball** _____ ☐ **Softball** ____ ☐ **Martial Arts** _____ ☐ **Soccer** ____

☐ **Other** _____

Describe your Regular Excercise Activities & Frequency:

☐ **Weight Training** _____ ☐ **Free Weights** ___ ☐ **Machine Circuit** ____ ☐ **Aerobic** _____

☐ **Running** _____ ☐ **Cycling** ___ ☐ **Swimming** _____ ☐ **Walking** _____

Other

Describe your Workday Activities: ☐ **Sitting** % ☐ **Standing Walking** % ☐ **Computer** %

☐ **Lifting** % up to lbs ☐ **Travel** % ☐ **Plane** ☐ **Car**

PT NOTES

SUBJECTIVE REPORTING: Description of Symptoms/Limitations

Describe Your Symptoms: _____

What Activities Make it Worse? _____

What Makes your Symptoms Better? _____

Describe Limitations this Condition has Imposed: _____

PT NOTES

_____ _____ _____ _____

Patient (or Legal Guardian) Signature **Date** **Physical Therapist Signature** **Date**