SCARBOROUGH ORTHO & SPORT
Physical Therapy

Name:_____ DOB: ____/___/_____

Description of current problem: _____

When and how did your problem begin: _____

_____

Rate your pain: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Describe pain:

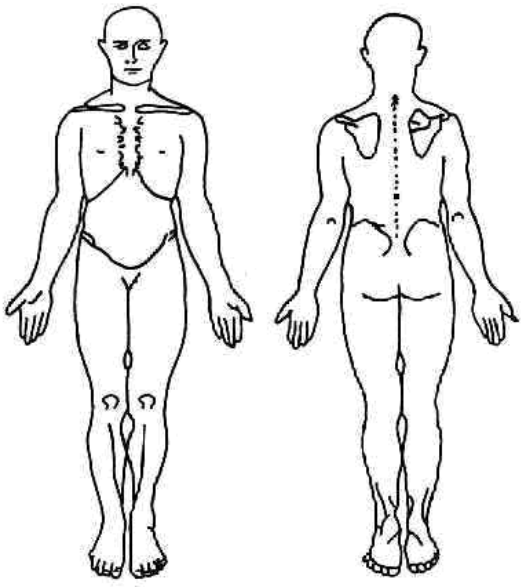
- ☐ sharp
- ☐ dull
- ☐ burning
- ☐ ache
- ☐ numb/tingling

- ☐ Constant
- ☐ Intermittent

Are you getting:

- ☐ Better
- ☐ Worse
- ☐ Staying the same

Fill in the areas you are experiencing symptoms:



What makes your symptoms worse?

_____
_____
_____

What makes your symptoms better?

_____
_____
_____

Have you had this problem before? Yes No

If yes, what made it better?_____

Have you had imaging? X-Rays MRI CT scan other:_____

Past Medical History:

high blood pressure	kidney disease	osteoporosis	dizziness
heart disease	diabetes	depression	vertigo
high cholesterol	cancer	anxiety	stroke
pacemaker	circulatory problem	arthritis	other:_____
lung disease	asthma	seizures	other:_____

Please list any surgeries:_____
Please list any allergies:_____

Contact Information:
The number provided will be used to contact you regarding appointments or to leave you messages that may have detailed information about your schedule or treatment.
Phone Number: _____

Emergency Contact:_____Relationship:_____

Consent to Treat:
Please initial each section to demonstrate you have read and understood the section.

___ I consent to and authorize Scarborough Orthopedic and Sports Physical Therapy to administer a physical therapy evaluation and treatment. I voluntarily give consent to such routine evaluation procedures and physical therapy treatments as determined by Alison Davis, PT to be necessary and desirable based on her exercise of professional judgment. If you are under 18, you must have a parent or guardian signature.

___I understand there are no guarantees with physical therapy treatments and services.

No Show Policy:
___I have read and understand the no show and cancellation policy. I understand I will be charged $20 for every no show appointment. No show appointments are defined as scheduled visits unattended without advanced cancellation. Please provide at least 2 hours advanced notice of cancelled appointments.

Signature:_____Date: _____

Parent Signature (if under 18)_____ Date: _____