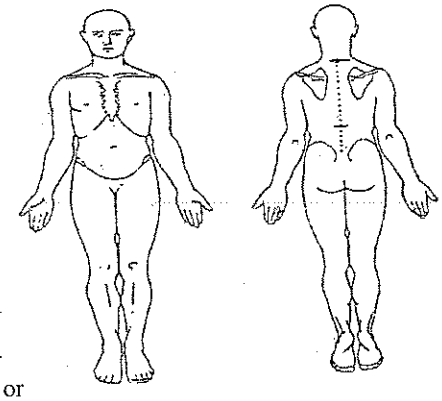
CAROLINA ORTHOPEDICS
SPORTS MEDICINE & PHYSICAL THERAPY



Name: _____ DOB: _____

Reason for Therapy: _____

Please indicate areas where you are currently having problems by *marking on the diagram to the right.*

Please describe type of injury/surgery and approximate date of onset:

_____

_____

Are you currently receiving or have you had therapy including home therapy or chiropractic services this year? Yes No

What goals would you like to achieve with therapy? _____

Have you fallen in the last year? (If Yes, how many times?)_____

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

Are you currently experiencing or have you experienced any of the following?

Heart Disease	Yes	No	Kidney Problems	Yes	No
High Blood Pressure	Yes	No	Seizure	Yes	No
Vertigo/Dizziness	Yes	No	Cancer	Yes	No
Metal Implants	Yes	No	Anxiety/Depression	Yes	No
Stroke	Yes	No	Allergies/Skin	Yes	No
Diabetes	Yes	No	Hernia	Yes	No
Pacemaker	Yes	No	Shortness of Breath	Yes	No
Headaches	Yes	No	Pregnant/IUD	Yes	No
Hepatitis A/B/C	Yes	No	HIV/AIDS	Yes	No
Smoke __pack/day	Yes	No	Numbness/Tingling	Yes	No
Weight Loss/gain	Yes	No	Pain with cough/sneeze	Yes	No

Other Medical Conditions:_____

Allergies: _____

Please list any medications or supplements you are currently taking: _____

_____

Thank you for choosing Carolina Physical Therapy & Sports Medicine as your rehabilitation provider. We look forward to helping you achieve your rehabilitation goals. **Keeping your scheduled appointments and performing your prescribed home exercise program are very important components to your plan of care. If you are unable to attend any of your treatment sessions please contact us as soon as possible. It is important to your recovery that you participate fully in your treatment program: excessive absences/missed sessions will be considered noncompliance and may result in your discharge from therapy.**

I am consenting to evaluation and treatment at Carolina Physical Therapy & Sports Medicine.
I understand that after an evaluation is performed my therapist will outline a plan of care.
I understand that I may refuse any portion of treatment at any time.

Signature: _____ Date: _____