BETTER WELLNESS PT

FEEL BETTER. BE BETTER.

251 River Street Troy NY 12180
518-421-4468
betterwellnesspt@gmail.com

Name: _____ **Date:**_____
Primary Care Physician:_____
Address:_____
Phone:_____
Email:_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in bowel or bladder function
- ❑ nausea/vomiting
- ❑ dizziness/lightheadedness
- ❑ difficulty maintaining balance while walking
- ❑ weight loss/gain
- ❑ shortness of breath
- ❑ headaches
- ❑ changes in appetite
- ❑ fever/chills/sweats
- ❑ pain at night
- ❑ weakness/fatigue
- ❑ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer (type)_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ asthma
- ❑ pacemaker inserted
- ❑ osteoporosis
- ❑ chemical dependency (i.e., alcoholism)
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ depression
- ❑ anemia
- ❑ lung problems
- ❑ thyroid problems
- ❑ other_____
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ kidney/liver problems
- ❑ stomach ulcers
- ❑ epilepsy
- ❑ Parkinson's disease
- ❑ other_____

NO Do you smoke? Yes No _____ pack/day
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications:_____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO ALLERGIES:**
_____ **Latex sensitive? Yes No Tape Allergies? Yes No**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1. _____ 2._____ 3._____

Pain at Worst: Rate you worst pain level in past 24 hrs.

None 1 2 3 4 5 6 7 8 9 10

What makes the pain better? _____

What makes the pain worse?_____

Have you seen an MD for this reason?_____

Did they send for your imaging?_____

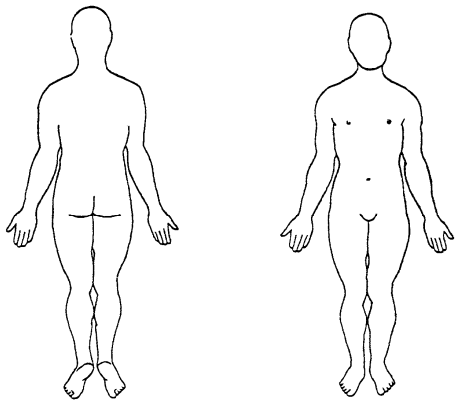
What was the Diagnosis?_____

What have you tried already to improve your symptoms?_____

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Burning



List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms.

_____ (ex. Stairs, reaching overhead)

What is your goal for therapy at this time?_____

CONSENT FOR CARE & TREATMENT: I, the undersigned, do hereby agree and give my consent for Heather Flexer, PT, DPT doing business as Better Wellness PT to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical condition.

Patient Signature_____ **Date:**_____

Parent Signature if Patient is under 18_____ **Date:**_____