Beth Israel Lahey Health
Winchester Hospital

Patient Medical Record Number: _____
Patient Name: _____
Patient Email: _____
I am a new patient: **yes** **no**
I am a returning patient: **yes** **no**
I have had physical therapy this year: **yes** **no**

Physical Therapy

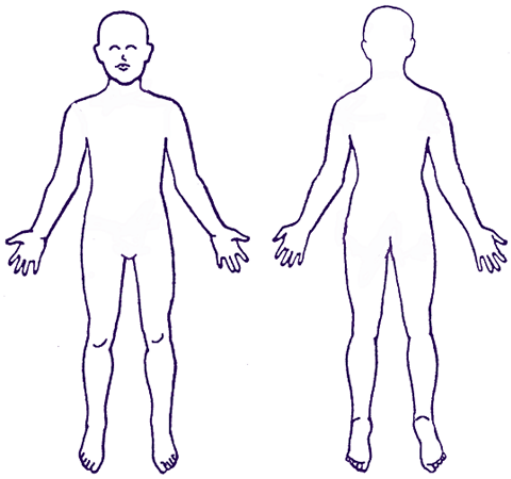
Primary Care Physician: _____ **Referring Physician**: _____

1. History of Present Illness:

What brings you here today? _____ When did symptoms start? _____
Is this visit related to an auto accident? Yes No
Is this visit related to a work injury? Yes No
Previous history of similar symptoms Yes No
Previous treatments for similar symptoms Yes No
Have you had any Physical, Occupational
Or Speech Therapy this year? Yes No If yes, why? _____
What is your current occupation? Are there any physical requirements? _____

2. Pain Location, Description, Scale:

Pain Location: (Please place an x on the body picture where you have pain)



Do you have difficulty with?

- ☐ Walking
- ☐ Getting Dressed
- ☐ Climbing Stairs
- ☐ Moving from sitting to standing
- ☐ Balance
- ☐ Household Chores
- ☐ Disturbed Sleep
- ☐ Recreational Activities

Pain Description: (for example sharp, dull, achy) _____

Pain Scale: (Please circle or place an x: 0 means none, 5 means moderate and 10 means extreme or severe)

Worst Pain:	0 1 2 3 4 5 6 7 8 9 10
Current Pain:	0 1 2 3 4 5 6 7 8 9 10
Best Pain:	0 1 2 3 4 5 6 7 8 9 10

3. Fall/s History:

Do you experience unsteadiness, loss of balance while walking? yes no

Do you use an assistive device? (cane, walker, crutch, etc.) yes no If yes, which type _____

Have you fallen in the past year? yes no

If you have fallen, how many times? _____

What is your goal for therapy at this time?

4. Medical History

Is there any other information regarding your medical history that we should know about (i.e. Diabetes, Osteoarthritis, Cancer)?

What Diagnostic tests/ procedures have you undergone related to this problem (ie x-rays, MRI, EMG, surgery)?

Current Medications: (If you receive your primary care at a Winchester, Lahey, or Beth Israel location your medications should be in our electronic medical record system)

☐ Not currently taking any medications
☐ Prescription
☐ Non Prescription/Over the Counter/Vitamin/Mineral/Dietary Supplements/Herbal/Other

Patient Signature: _____Date: _____

Guardian/Representative Signature: _____Date: _____