SPINESCOTTSDALE PHYSICAL THERAPY

Moving in the Right Direction

SPINEOSTEOPOROSIS
PATIENT PRE-ASSESSMENT FORM

Name: _____ Date of Birth: _____Today's Date: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

SpineScottsdale Physical Therapy will use your e-mail to send newsletters, appointment reminders, and other physical therapy related information. If you do not give your permission for this e-mail correspondence, please indicate on the E-mail Address line above.

Emergency Contact: _____ Phone Number: _____

How did you choose SpineScottsdale Physical Therapy? _____

Referring Physician: _____ Primary Care Physician: _____

Do you have a follow up appointment with your referring physician? No:_____, Yes: _____(date)_____

_____

Please provide the following information

1. Have you had a bone density test in the last 2 years? Yes No
   If yes, please bring your test results with you or have your physician fax us a copy. Our fax number is: 480-272-9369

2. Have you fallen within the past 3 months? Yes No If yes, please explain:

   _____

3. Are you up on your feet at least four hours per day? Yes No

4. How many hours collectively do you spend sitting in a day? _____

5. Have you noticed increased pain in any body part? Yes No If yes, please describe what body part:

   _____

6. What are your specific goals for physical therapy? _____

7. What is your major concern about your condition? _____

8. Is there anything else you would like to tell me that you think would help me treat you? _____

   _____

10277 N. 92nd St., Suite 103, Scottsdale, AZ 85258
Ph: (480) 584-3334 Fax: (480) 272-9369
www.spinescottsdale.com

MEDICAL HISTORY

Please list any **medications** you are taking for your current condition that you are being seen for.

1._____ Dosage? _____ How many pills per day? _____

2. ._____ Dosage? _____ How many pills per day? _____

3. ._____ Dosage? _____ How many pills per day? _____

Any unexplained night pain: Yes No

Any unexplained weight loss: Yes No

Please list any recent or major orthopedic surgeries with dates:

1._____ 2._____

Is there a possibility you are pregnant? Yes No

Do you currently have or have you had in the past any of the following?

Cardiac/Heart Problems	Yes	No	
Pacemaker/Defibrillator	Yes	No	
Cancer	Yes	No	If yes, is your cancer gone? Yes No N/A
Spinal Stimulator	Yes	No	

Is there anything else we should know? ____ No _____Yes: _____

Please circle the following that apply to you: I play golf I have a desk job I want to join a fitness facility

I understand that I am responsible to inform the physical therapist of any health problems and allergies I have, as well as any drugs or medications I am taking. I further understand that I am responsible to inform the physical therapist of any changes in your medical status during the course of treatment.

Patient Signature: _____ Printed Name: _____ Date: _____

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