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**Brooklyn Bodyworks**

**Physical Therapy, P.C.**

## **New Patient Medical History**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Occupation: \_\_\_\_\_ Gender: M F

Diagnosis/Condition: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Date of 1<sup>st</sup> MD visit for this injury: \_\_\_\_\_

When did you first notice symptoms of your problems? \_\_\_\_\_

Did your symptoms arise gradually? Yes No Was there a sudden onset? Yes No

Was there any trauma/accident that may have caused your complaints/ problems? Yes No

Please elaborate: \_\_\_\_\_

What are your present symptoms? \_\_\_\_\_

How do your present symptoms compare to your original complaint?

Rate your pain on a scale of 0 (No Pain) to 10 (Excruciating pain that is disabling and requires emergency care)

At the best moment in the 48hrs \_\_\_\_\_ During the night \_\_\_\_\_

At the worst moment in the 48hrs \_\_\_\_\_ Is pain constant or intermittent (circle one)?

Does your pain wake you up at night? Yes No

Does your pain fluctuate depending on your activities? Yes No

Does your pain follow a pattern where it is worse in the am or pm (circle one)? Yes No

Does your pain radiate from one area to other areas? Yes No

What activities of daily living are painful or difficult for you because of your problem?

What can you do to alleviate the pain? \_\_\_\_\_

Do you normally participate in any fitness activities or recreational sports? Yes No

If so, please list:

How have you modified your activities? \_\_\_\_\_

Did your referring MD give you any instructions (i.e. for exercise, weight bearing, weaning from crutches, and use of a brace)? Yes No

Please elaborate: \_\_\_\_\_

Have you sought care from any of the following medical providers for this injury/episode? Please indicate

Emergency Room Care: \_\_\_\_\_ General Practitioner: \_\_\_\_\_ Acupuncturist: \_\_\_\_\_

Orthopedist: \_\_\_\_\_ Physical Therapist: \_\_\_\_\_ Message Therapist: \_\_\_\_\_

Neurologist: \_\_\_\_\_ Chiropractor: \_\_\_\_\_ Podiatrist: \_\_\_\_\_

Occupational Therapist: \_\_\_\_\_ Other: \_\_\_\_\_

Have you had any diagnostic tests performed? Yes No

If so, please indicate which test(s) and appropriate date(s):

X-Ray: \_\_\_\_\_ MRI: \_\_\_\_\_ Other: \_\_\_\_\_

Have you missed any work due to this injury? Yes No

If so, what was your last day of work? \_\_\_\_\_ Date returned to work: \_\_\_\_\_

Worked part-time for period of: \_\_\_\_\_

Have you had surgery for this injury? Yes No Surgeon: \_\_\_\_\_

Procedure(s) performed: \_\_\_\_\_

Most recent surgery performed: \_\_\_\_\_

Are you currently taking any medications (for this condition or anything else)? Yes No

Please list the appropriate categories:

Anti-inflammatory: \_\_\_\_\_ Pain Medications: \_\_\_\_\_

Muscle Relaxers: \_\_\_\_\_ Antibiotics: \_\_\_\_\_

Other: \_\_\_\_\_

