



Capital Region Physical Therapy, PLLC
1220 New Scotland Road, Suite 103, Slingerlands, NY 12159
518-439-5006

New Patient History Form

Welcome to Capital Region Physical Therapy. Please take a moment to provide us with some information about your current condition that brings you to our clinic.

Name: _____ Social Security #: _____

Date of Birth: _____ Phone #: _____

Address: _____

Occupation: _____ Employer: _____

Insurance: _____ Member ID: _____

Name of Insured: _____ Relationship to Patient: _____

1. What problem brings you to physical therapy?

2. Briefly describe how and when your problem began.

3. Please circle the symptoms that you are feeling.

Pain Weakness Numbness Tingling Other _____

4. What makes your symptoms worse? _____

5. What makes your symptoms better? _____

6. Does your condition interfere with your normal work or recreational activities? _____

7. Please circle the diagnostic studies that have been performed for this condition.

X-ray MRI CT scan Bone Scan EMG/NCV test

8. Please circle the treatments you have had for this condition.

Physical Therapy Injections Chiropractic Massage Surgery

9. Please indicate if you currently have or have had any of the following:

___ High cholesterol	___ Cancer	___ HIV/AIDS
___ High blood pressure	___ Diabetes	___ Pregnant (or may be)
___ Cardiac surgery	___ Osteoporosis	___ Hip replacement
___ Vascular problems	___ Respiratory problems	___ Knee replacement
___ Pacemaker	___ Seizure disorder	___ Metal implants

___ Other (please describe) _____

___ No significant past medical history.

10. What is your goal for physical therapy? _____

Signature: _____

Date: _____