Bella Physical Therapy • 39-40 Broadway, Suite 4, 2nd Floor • Fair Lawn, NJ 07410
Phone: 201-791-0008 • Fax: 201-791-7111 • Email: bellaphysicaltherapy@gmail.com
www.bellaphysicaltherapy.com • Hours: Mon-Fri, 10 am to 8 pm • Closed Saturday and Sunday

Today's Date: _______________
Patient's Name: _________________________________ **Date of Birth:** ______________

Briefly describe your chief complaints / reason for coming to Physical Therapy? _______________
____
____

Have you had any tests for this condition? ☐ MRI ☐ X-ray ☐ Blood work ☐ Other ________________________
Have you attended Physical Therapy before? ☐ YES ☐ NO If Yes, when: _____________________________________

MEDICAL HISTORY:

Have you RECENTLY noted any of the following? (Circle Y for Yes or N for No):

Y / N changes in bowel or bladder function
Y / N nausea/vomiting
Y / N dizziness/lightheadedness
Y / N difficulty maintaining balance while walking
Y / N changes in sleeping habits/lethargy
Y / N changes in vision (blurring, double, narrowing)
Y / N weight loss/gain
Y / N shortness of breath
Y / N headaches
Y / N changes in appetite
Y / N changes in energy level/fatigue
Y / N recurrent thoughts of death or harming yourself
Y / N fevers/chills/sweats
Y / N pain at night
Y / N weakness
Y / N difficulty swallowing
Y / N changes in mood

Have you EVER been diagnosed with any of the following? (Circle Y for Yes or N for No):

Y / N cancer (including skin), type_____________
Y / N heart disease
Y / N high blood pressure
Y / N congenital heart abnormality / murmur
Y / N pacemaker or other device inserted
Y / N musculoskeletal / orthopedic problem
Y / N kidney or urinary problems
Y / N liver problems or jaundice
Y / N epilepsy / seizure disorder
Y / N sexually transmitted disease
Y / N intolerance to heat or cold
Y / N Arthritis (circle one): Rheumatoid Psoriatic Osteo Other
Y / N lung problems
Y / N osteoporosis/osteopenia
Y / N heart attack
Y / N thyroid problems
Y / N anemia, bleeding or clotting disorder
Y / N chemical dependency/alcoholism
Y / N depression or emotional problems
Y / N ulcers (stomach or peptic)
Y / N Colitis (Chrone's or Ulcerative)
Y / N skin problem (eczema, psoriasis, etc)
Y / N neck or back problems
Y / N asthma
Y / N stroke
Y / N diabetes
Y / N Multiple Sclerosis
Y / N head injury
Y / N Lupus
Y / N eating disorder
Y / N Parkinson's disease

Please list any SURGERIES or HOSPITALIZATIONS, including dates:
____

Please list all current medications (prescription or over-the-counter) and supplements:
____

Please list all allergies: ____
Are you latex sensitive? Yes No

FOR WOMEN:
Current pregnancy: ____
Past pregnancies: ____
Gynecological problems: ____

Family Medical History: Please circle Y for Yes and N for No regarding your parents, siblings, or children

Y / N allergies
Y / N high cholesterol
Y / N migraine headaches
Y / N cancer
Y / N high blood pressure
Y / N seizure disorder
Y / N diabetes
Y / N mental illness/depression
Y / N heart disease

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Regain. Renew. Recover.

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PATIENT QUESTIONNAIRE

Are you presently working? **Yes** **No** If NO, since:____________________________________

Overall daily activity level: **Sedentary** **Light** **Moderate** **Heavy** **Very Heavy**

Sports or Exercise (type, frequency and duration):____

Do you use tobacco? **Yes** **No**
Do you use alcohol? **Yes** **No** If YES, how many glasses per week? _____

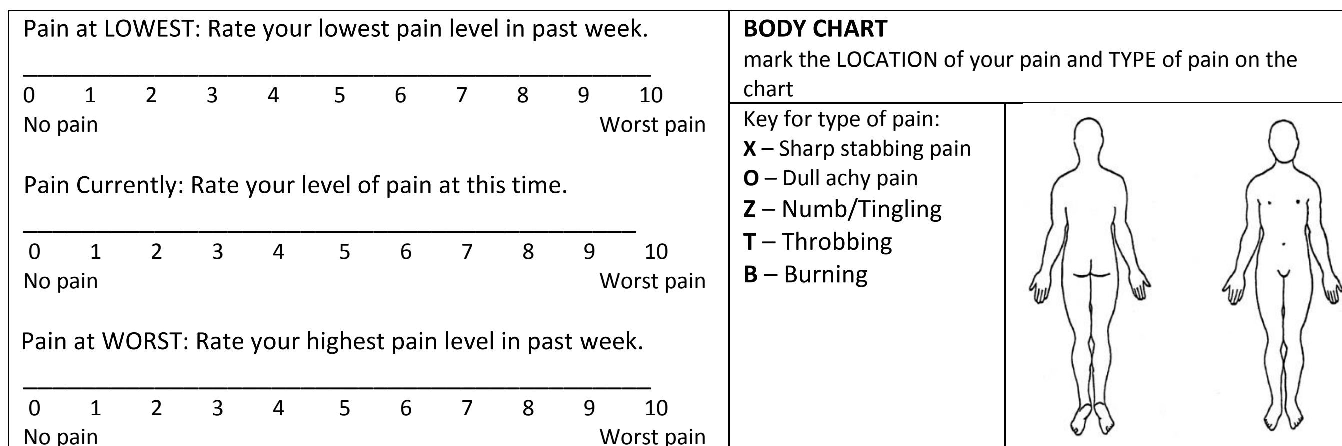
How much water do you drink per day? _____________

How many caffeinated beverages per day? ________

Do you like to eat: Dairy **Yes** **No** Sweets/Sugar **Yes** **No** Salt/Salty Food **Yes** **No**

Do you have gluten sensitivity? **Yes** **No**

Please answer the following in regards to your chief complaint:
WHEN and HOW did this problem begin? ____



Pain at LOWEST: Rate your lowest pain level in past week.
____
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Pain Currently: Rate your level of pain at this time.
____
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Pain at WORST: Rate your highest pain level in past week.
____
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

BODY CHART
mark the LOCATION of your pain and TYPE of pain on the chart

Key for type of pain:
X – Sharp stabbing pain
O – Dull achy pain
Z – Numb/Tingling
T – Throbbing
B – Burning

What makes your symptoms worse? ____

What makes your symptoms better? ____

Are your symptoms worse in the (circle one): **Morning** **Afternoon** **Evening** **Night** **Inconsistent**

Are your symptoms (circle one): **Improving** **Worsening** **Stable**

List ONE important activity you currently are unable to perform or have difficulty performing as a result of your pain/symptoms, and circle pain scale number: ____

What is your primary goal for physical therapy at this time? ____________________________________