Performance Physical Therapy of Naples, Inc. N P E

Medical Information

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____

Surgical History (Check Box)

		Date of Surgery		Date of Surgery
□ Knee Arthroscopy	□ L □ R		□ Neck Surgery	
□ Knee Replacement	□ L □ R		□ Back Surgery	
□ Hip Replacement	□ L □ R		□ Cancer Removal	
□ Shoulder	□ L □ R		□ Other	
□ Heart Procedure (Bypass or Stent)				

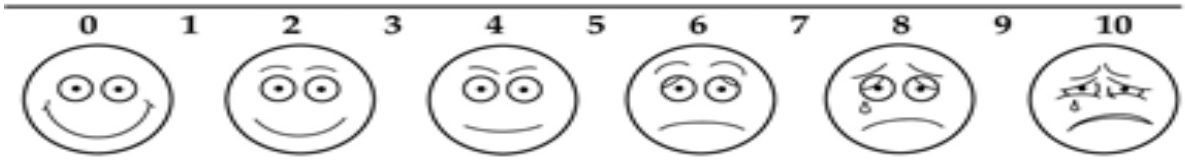
Medical Condition (Check Box)

	Date of 1st Occurrence		Date of 1st Occurrence
□ High Blood Pressure		□ Cancer (Type)	
□ High Cholesterol		□ Osteoporosis	
□ Diabetes		□ Stroke	
□ Osteoarthritis		□ Pacemaker	
□ Cardiac Arrhythmia		□ Other	

Medications **** If you have a medication list please allow us to copy it at the front desk ****

Current Medications	Dosage	Frequency	Reason
		1 2 3 / Day or As Needed	
		1 2 3 / Day or As Needed	
		1 2 3 / Day or As Needed	
		1 2 3 / Day or As Needed	
		1 2 3 / Day or As Needed	
		1 2 3 / Day or As Needed	

Treatment Related to Current Condition	Start Date	End Date	Improved
□ Primary Physician			□ Y □ N
□ Orthopedic Surgeon			□ Y □ N
□ Physical Therapy			□ Y □ N
□ Pain Management Clinic			□ Y □ N
□ Chiropractor			□ Y □ N
□ Neurologist			□ Y □ N



0	1	2	3	4	5	6	7	8	9	10
No pain		Mild, annoying pain		Nagging, uncomfortable, troublesome pain		Distressing, miserable pain		Intense, dreadful, horrible pain		Worst possible, unbearable, excruciating pain