ALLY Physical Therapy, LLC
2460 Lemoine Avenue Suite 204 Fort Lee, NJ 07024
Tel: 201-742-1114 | Fax: 201-482-8757

Date: _____

Patient Name: _____ D.O.B. (MM/DD/YYYY): _____

Latex Allergy? Y N

Patient Screening

Briefly discuss why you are seeking consultation today:

_____

_____

Do you have or have had any of the following conditions?

			Comments
High Blood Pressure	Yes	No	_____
Presence of pacemaker	Yes	No	_____
Congestive heart failure	Yes	No	_____
Deep Vein Thrombosis	Yes	No	_____
Pulmonary Embolism	Yes	No	_____
Asthma	Yes	No	_____
Emphysema	Yes	No	_____
Chronic Bronchitis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes Mellitus	Yes	No	_____
Fracture	Yes	No	_____
Osteoporosis	Yes	No	_____
Sprain/Strain	Yes	No	_____
Osteoarthritis	Yes	No	_____
Rheumatoid Arthritis	Yes	No	_____
Thyroid Problems	Yes	No	_____
Multiple Sclerosis	Yes	No	_____
CVA	Yes	No	_____
Parkinson's Disease	Yes	No	_____
Anemia	Yes	No	_____
Chemical Dependency	Yes	No	_____
Depression	Yes	No	_____
History/Recent Surgery	Yes	No	_____
History/Recent Hospitalization	Yes	No	_____
Other			_____

Do you have any allergies (food, medication, latex)? _____

Have you fallen within the past 6 months? _____ If yes, how many times?_____

Have you been feeling unsteady on your feet or feel like you will lose your balance? _____

Have you used an assistive device or are currently using one? _____

Have you recently experienced any of the following?

			Comments
Unintended weight loss	Yes	No	_____
Nausea or vomiting	Yes	No	_____
Fatigue	Yes	No	_____
Weakness	Yes	No	_____
Fever, chills, sweats	Yes	No	_____
Lightheadedness / dizziness	Yes	No	_____
Numbness / tingling	Yes	No	_____
Migraines / headaches	Yes	No	_____
Shortness of breathing	Yes	No	_____
Are you or were you a smoker?	Yes	No	If yes, how many packs per day? _____

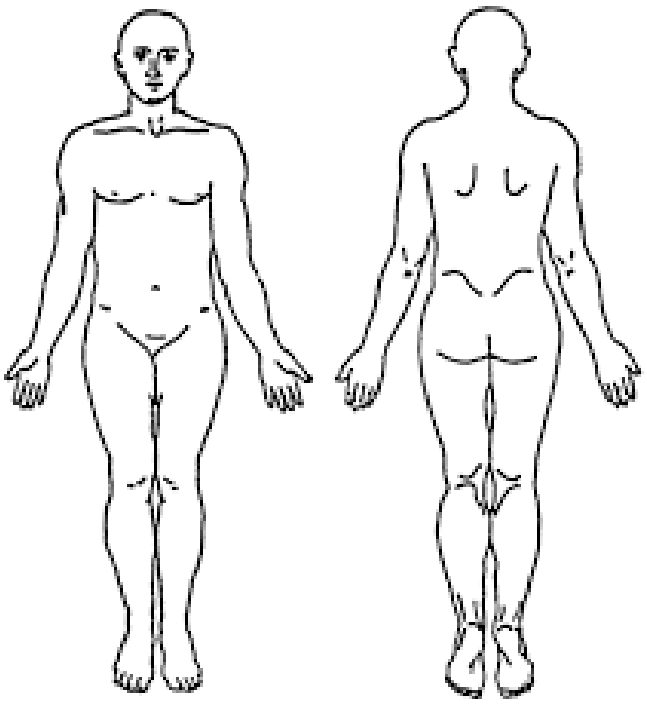
Have you done any of these diagnostic imaging within the past 6 months?

			Comments
X-Ray	Yes	No	_____
Bone Scan	Yes	No	_____
Doppler US	Yes	No	_____
CT Scan	Yes	No	_____
EMG	Yes	No	_____
NCV	Yes	No	_____
MRI / MRA	Yes	No	_____

Pain Scale

Please mark an P where your pain is located, T for tingling, N for numbness

Right Left Left Right



Please indicate your pain levels (0 is no pain and 10 is the worst pain)

Present pain: _____ / 10
Pain at its best: _____ / 10
Pain at its worst: _____ / 10
Pain goal: _____ / 10
Pain location: _____
Pain frequency: Constant: _____ Intermittent: _____
Pain descriptors: Sharp _____ Heavy _____ Dull _____ Cramping _____ Pressure _____
Burning _____ Tingling _____ Other_____

What makes your pain better? _____
What makes your pain worse? _____

What's your goal for physical therapy?
_____

Signature of Patient or Legal Guardian: _____ Date: _____

Physical Therapist Signature: _____ Date: _____