MACCIO PHYSICAL THERAPY, PLLC

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(518) 273-2121

Returning Patient Questionnaire

Are you currently receiving **Home Health Care**? Y / N

Are you currently receiving **Speech Therapy**? Y / N

Have you had or are you currently receiving **Chiropractic Care** this year? Y / N

Have you had previous **Physical Therapy** by any other provider in the last year? Y / N

Primary Physician: _____ Referring MD: _____

If your address, insurance or phone number has changed please notify the front desk.

I acknowledge that the above information is correct to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

Maccio Physical Therapy, PLLC.
1 New Hampshire Ave.
Troy, NY 12180
(518) 273-2121

GENERAL MEDICAL HISTORY

Name:_____ Referring Physician:_____

Emergency Contact:_____ Relationship:_____

Contact's Home Phone:_____ Contact's Work Phone:_____

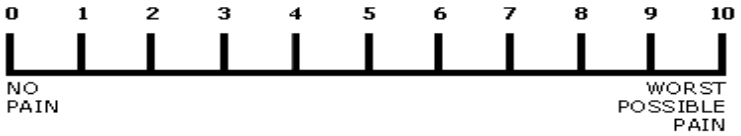
Please circle if you are allergic to any of the following: Chlorine Iodine

Other Allergies:_____

Current Medications (please include dosage):_____

_____

What is the average intensity of your symptoms?



Please circle any of the following which apply to you. Please explain any circled responses in the space below

Asthma	Headache	Paralysis
Arthritis	Hearing Difficulties	Pins and Needles
Blood disorders	Heart Attack	Pneumonia
Cancer	Hepatitis	Pregnant (currently)
Chest Pain	High/Low Blood Pressure	Seizures
Cyanosis	High/Low Pulse	Sprain/Strain
Diabetes	HIV+/AIDS	Stroke
Dizziness	Inhaler	Swelling
Emphysema	Joint Pain	TB
Faint Feeling	Joint Replacement	Tremor
Fracture	Numbness	Varicosities
Gastrointenstinal	Other	Visual Problems
Genito-urinary	Pacemaker	Weakness

EXPLANATIONS:_____

_____

I acknowledge that the above information is correct to the best of my knowledge.

Patient (or Guardian) Signature:_____Date:_____

Please tell us how you are feeling today

Patient Name_____**Date**_____

1. Describe your symptoms_____

_____

A. When did your symptoms start?_____

B. How did your symptoms start?_____

2. How often do you experience your symptoms?

A. Constantly (76—100% of the day)
B. Frequently (51—75% of the day)
C. Occasionally (26– 50% of the day)
D. Intermittently (0—25% of the day)

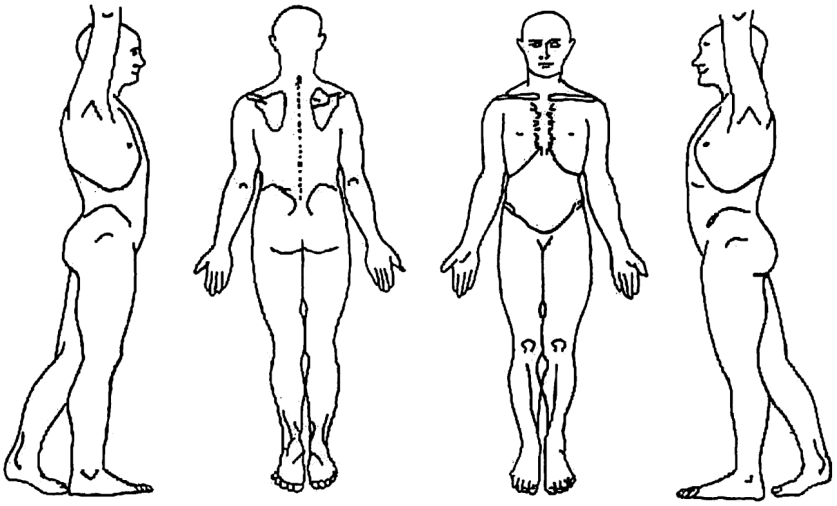
3. What is the nature of your symptoms?

A. Sharp
B. Dull ache
C. Numb
D. Shooting
E. Burning
F. Tingling

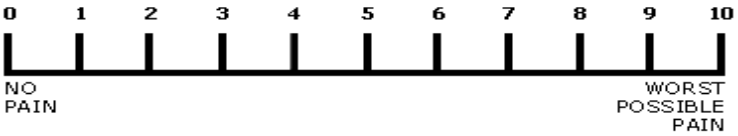
4. How are your symptoms changing?

A. Getting better
B. Not changing
C. Getting worse

Indicate on the diagrams where you have pain or other symptoms



5. During the past 4 weeks indicate the average intensity of your symptoms on the scale:



6. During the past 4 weeks how much has pain interfered with your normal work (outside the home and household)

A. Not at all B. A little bit C. Moderately D. Quite a bit E. Extremely

Please answer the last 5 questions as best you can:

7. What are you unable to do because of your current condition?

8. To what degree is this important to you?

9. How does this condition affect your livelihood?

10. Do you think physical therapy can help you?

11. What results do you hope to see from physical therapy?

For Medicare Patients Only

1. **Have you had 2 or more falls in the past year?**
   Yes No
2. **Have you had any falls resulting in injury?**
   Yes No

Therapist Initials_____**Date**_____