



Physical Therapy

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MOMENTUM PHYSICAL THERAPY PATIENT INFORMATION FORM

TODAY'S DATE _____

Name _____ Age _____ D.O.B. _____

Employer _____

Date of Injury/Onset of Pain _____

Referring Physician _____ Next appointment with referring physician _____

Chief Complaint: What is the nature of your pain or problem? _____

List the names of all the health professionals you have seen for treatment for this condition _____

Injury work related? YES NO Injury motor vehicle related? YES NO

If yes, are you currently working with an attorney for this? YES NO

Name of attorney? _____

Address: _____

Are you taking any medications? Please list _____

Are you allergic to LATEX? YES NO

Do you now have, or have you had, any of the following?

High blood pressure	YES NO	Seizures	YES NO
Heart disease/attack	YES NO	Metal Implants	YES NO
Dizziness	YES NO	Chronic Headaches	YES NO
Cancer	YES NO	Previous Physical Therapy	YES NO
Pregnant (currently)	YES NO	Tooth or jaw pain	YES NO
Previous surgery	YES NO	Knee support/brace	YES NO
Diabetes	YES NO	Back support/brace	YES NO

If you answered YES to any of the above, please explain and give approximate dates: _____

Please indicate on the pictures to the right the locations of your pain.

Please indicate your level of pain at its WORST and BEST on the scale below

0 1 2 3 4 5 6 7 8 9 10
0=NO PAIN 10=EXCRUCIATING PAIN

