RECLAIM
PHYSICAL THERAPY

New Therapy Case Form

Patient Name:	Patient DOB:

Please provide a brief description of what complaint or concern has caused you to seek therapy services:

From 0-10, what is your pain level over the last 48 hours? *(0 is no pain, and 10 is the worst imaginable)*	Current:	Best:	Worst:

What activities that you would like to perform are you unable to?	What provokes and/or relieves your symptoms?

Please check all that apply to your current health, or health history.

☐ Heart Attack ☐ Chest pain or coronary artery disease ☐ Stroke or TIA ☐ Cancer Select one: Current ○ Past history ○ ☐ Lung Condition/Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Osteoporosis ☐ Arthritis Location:_____ ☐ Dizziness/Fainting ☐ Hypoglecemia (Low blood sugar) ☐ History of seizures ☐ Pregnant	☐ Anxiety/depression ☐ History of falls ☐ Latex allergy ☐ Pacemaker ☐ Recent/ related surgery If so, describe _____ _____ ☐ Other problems- please list below _____ _____ _____

Please check all as they relate to your injury or condition

☐ New injury	☐ Athletic injury	☐ Work related injury	☐ Injury related to a fall	☐ Recurrence of condition	☐ Unknown cause	☐ Motor vehicle accident

*A*re you currently receiving any home health services? ○ Yes ○ No