NORTHEAST REHABILITATION, INC.

HAND THERAPY, ORTHOPEDIC AND SPORTS PHYSICAL THERAPY

Sudhir V. Tawalare, PT, OCS, CHT. NY License 012255-1, NJ License 40QA00594800

Maria Moldovan, PT NY License 027305

Name:_____ DOB:_____

To help us better evaluate your condition please complete this form to the best of your knowledge.
If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY:
Please check any condition you have a history of.
Items not checked are understood to be negative.

___High Blood Pressure	___Abnormal Bleeding	___Bowel or Bladder Problems
___Heart Problem	___Asthma	___Autoimmune disorder
___Abnormal Heart Rate	___Emphysema	___Recent sudden Weigh Loss/Gain
___Pacemaker	___Chronic Lung Problem	___Thyroid Problem (Hyper or Hypo)
___Heart Palpitations	___Chronic Heartburn	___Diabetes (medication dependent? YES/NO)
___Angina (chest pain)	___History of Ulcers	___Cancer/tumors (where?_____)
___Shortness of breath	___High Cholesterol	___Seizures/Epilepsy
___Osteoporosis	___Night sweats	___Chronic heartburn/Intestinal upset
___Arthritis	___Dizziness	___Hearing problems

Other:_____

_____

Do you have a history of fractures?	Yes	No	Where?_____
Do you have a history of back/neck pain?	Yes	No	When?_____
Do you have any metal implants?	Yes	No	Where?_____
Do you smoke?	Yes	No	How much per day?_____
Do you exercise regularly?	Yes	No	How Often?_ _____
Do you have any known allergies?	Yes	No	Please List:_____
			_____
Are you allergic to latex?	Yes	No	
Are you pregnant or suspect pregnancy?	Yes	No	

MEDICATIONS:
Please check if you are taking any of the following (Please list names of medications)

___Blood Pressure Medication	___Heart Medication	___ Diabetes Medication (i.e.Insulin)
_____	_____	_____
___Muscle Relaxants	___Pain Killers	__Anti-coagulants(blood thinners)
_____	_____	_____
___Steroids (Cortisone)	___ Anti-inflammatories	___Other Medications
_____	_____	_____

275 NORTH MIDDLETOWN RD, SUITE1B. PEARL RIVER. NY 10965

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SURGERIES: Please list all surgeries, including date:

_____

_____

_____

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density

( )Blood Chemistry ( )Ultrasound ( )Other (please specify)_____

Have you seen anyone else for your current problem?

( )Physician/MD ( )Chiropractor ( )Podiatrist ( )Orthopedic Surgeon ( )Dentist

( )Neurologist/Neurosurgeon ( )Osteopath/DO ( )Physical Therapist Date:_____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities?	Yes	No
Do you have any weakness in your arms or legs?	Yes	No
Do you have any coordination or balance problems?	Yes	No
Do you have difficulty walking?	Yes	No
Do you experience dizziness or vertigo with a change in position?	Yes	No
Have you experienced headaches as a result of your condition?	Yes	No
Have you had this problem before?	Yes	No

If yes, when?_____

_____

CHIEF COMPLAINT/ CURRENT CONDITIONS:

Please describe:_____

_____

Please rate your pain in this scale of 0-10.

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

I believe all information to be true and complete:

Signature:_____ Date:_____

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