Diamond Peak Physical Therapy
1542 Taurus Ct
Loveland, CO 80537
970-593-1442

Welcome to Diamond Peak Physical Therapy!

Patient Information

Today's Date _____ SSN# _____ Age _____

Name _____ Date of Birth _____

Address _____ Apt _____

City _____ State _____ Zip _____

Phone - Home _____ Cell _____ Work _____

Email Address _____

Emergency Contact Name _____ Phone _____ Relationship _____

Referring Dr _____ Primary Dr _____

Payment Information

- Medicare - please list secondary insurance _____
- Private Insurance Name _____
  Policy Holder's Name _____
- Work Comp Company _____ Claim# _____
  Contact Person _____ Date of Injury _____
  Address _____
- Accident: Motor _____ Other _____ Insurance Name to Bill _____
  Address _____
  Adjuster's Name/Number _____

Physical Therapy Questionnaire

Gender: Male/Female Pregnant: Yes/No Smoker: Yes/No Allergic to Latex? Yes/No

How often do you exercise? _____ Do you take blood thinners? Yes/No

Past Surgeries (list/date) _____

_____

Current Medications _____

Medical History: Please circle any conditions that you've been told you have or had

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Angina	Heart Disease	Fibromyalgia	Ulcers
Osteoporosis/Osteopenia	Osteoarthritis	Asthma	Lung Disease	Rheumatoid Arthritis

Please Fill Out Both Front and Back of Each Page. Thank you!

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Currently I am experiencing (circle all that apply):

Unexplained weight loss	Numbness/Tingling	Fever/chills/sweats	Poor balance (falls)
Depression	Shortness of Breath	Changes in appetite	Difficulty Swallowing
Changes in bowel or bladder function		Dizziness	Headaches
		Nausea/Vomiting	Increased pain at night

Have you had a recent illness (explain if yes)?_____

How are you able to sleep at night? Fine / Moderate Difficulty / Only with medication

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes/No

What date (approximately) did your symptoms start?_____

How (gradually, suddenly, injury)?_____

My symptoms are currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far?_____

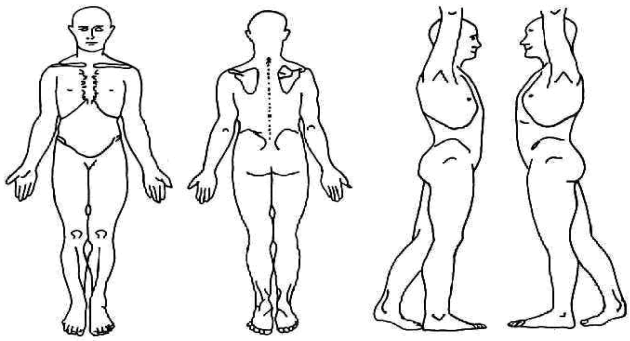
_____

What makes your symptoms better?_____

What makes your symptoms worse?_____

Have you had an X-ray, MRI or other imaging study for this problem? Yes/No What?_____

Body Chart: Please mark or shade the areas where you feel pain



On the scale below, please circle the number which best represents the **average** level of pain you have experienced over the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

What are your personal goals for therapy at this time?_____

_____

_____

Is there anything else you feel we should know to better help you?_____

_____