

Katonah Physical Therapy, P.C.

Patient Evaluation Form

Date: _____

Name: _____

Age: _____ **Height:** _____ **Weight** _____

Occupation: _____

1. Please describe your symptoms, when and how they started and any changes.

2. Have you ever had these or similar symptoms before? If so, please describe.

3. Are your symptoms, in any way, related to a motor vehicle or work related accident? If so, please explain.

4. Please describe any accidents, injuries or surgeries you have had.

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Date: _____

5. Do you have any of the following medical conditions?

	YES	NO
Rheumatoid Arthritis	_____	_____
High Blood Pressure	_____	_____
Heart Trouble	_____	_____
Pacemaker	_____	_____
Epilepsy	_____	_____
Diabetes	_____	_____
Pregnancy (currently)	_____	_____
Blackouts	_____	_____
Visual Disturbance	_____	_____
Dizziness	_____	_____
Weight Loss	_____	_____
(recent, more than 20 lbs)		
Headaches	_____	_____
Ringling In Ears	_____	_____

Other Conditions: _____

6. Please list any medications you are currently taking, and what condition you are taking it for.

7. Please list your goals for Physical Therapy.

