BROOKLYN BODY WORKS PHYSICAL THERAPY, P.C.
SPORTS & ORTHOPEDIC REHABILITATION

Medical History

1. Reason for physical therapy visit: _____

   Please describe your current symptoms: _____

   _____

2. **Is your condition work related or due to a motor vehicle accident?** ☐YES ☐ NO
   If YES, please inform the front office.
3. Have you had surgery for this condition? If so, please describe the procedure including the date of surgery:
   ☐NO ☐ YES, _____
4. Are you taking any medication for this condition? If so please list below:
   ☐NO ☐ YES, _____
5. Have you had physical therapy or other treatment for this condition in the past?
   If so, please describe your previous treatment:
   ☐NO ☐ YES, _____
6. When did your symptoms or injury first occur? Did your symptoms arise gradually or suddenly? Please describe:

   _____
7. Rate your current level of pain on a scale of 0 - 10 (0= no pain, 10=excruciating pain) _____
8. Is your pain constant or intermittent?

   _____
9. Does your pain wake you up at night? ☐ YES ☐NO
10. What activities make your pain worse?

    _____
11. Does your pain follow a pattern where it is worse in the AM or PM?

    _____
12. Do you have radiating pain that could be described as burning or electrical? ☐YES ☐NO
13. Do you have numbness or tingling in your one or more of your extremities (leg or arm)? ☐YES ☐ NO
14. Please describe your current functional limitations (walking, stairs, getting out of bed, recreational activities, etc):

    _____
15. Please list your normal recreational or sport related activities when healthy:

    _____

202 Union Avenue, Suite K, Brooklyn, N.Y. 11211 • Phone (718) 387-7420 • Phone/Fax (718) 387-7421
www.Bbwphysicaltherapy.com