

Cornerstone Physical Therapy Associates, LLC
64 Freetown Road, Suite 1
Raymond, NH 03077

Today's Date: _____
Date of birth: _____

NAME: _____

Reviewed cancellation/no show policy

Do you have a clear understanding of the financial implications to your care? Yes No

MEDICAL HISTORY

Known Drug Allergies: <input type="checkbox"/> NKDA	Current Medications: _____	Dose _____	Freq _____
	(Include over the counter and herbals)		
	_____	_____	_____
	_____	_____	_____
Are you allergic to Latex? <input type="checkbox"/>	Don't Know <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other Allergies?(pollen,dust) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, explain: _____			
Any food allergies? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, explain: _____			
Any significant weight change last 30days? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, explain: _____			
Are you pregnant ? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left handed <input type="checkbox"/> Right handed <input type="checkbox"/>

Have you ever been hospitalized? yes no

• If yes, please list all hospitalizations below.
Reason: _____ Date: _____

Have you received rehabilitation services before? Yes No If yes, PT , OT , other

• Injury: _____ Here or elsewhere? _____

Please check any of the conditions/ diseases you have had or now have, and give date of onset:

Date	Date	Date
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy/ seizure
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Fractures/ Broken Bones	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart disease/ attack	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Metal Implants
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Concussion/ Head injury	<input type="checkbox"/> Gynelological Problems	<input type="checkbox"/> Fever

Any other Medical conditions? _____

Current Problem that you are seeking treatment for: _____

How do you learn best? Seeing Hearing Doing

Is English your Primary language? Yes No If No, what language? _____

Do you smoke? Yes No How many packs per day? _____

Do you drink alcohol? Yes No How many drinks per day? _____

Are you in a relationship where you could be hurt or threatened in any way? Yes No

Are there any religious/cultural needs pertinent to your care? Yes No

Do you live alone? Yes No If, yes, do you receive assistance & from whom? _____

For children under age 15 are immunization up to date? Yes No

How did you hear about us? _____

Patient History completed by: _____
Reviewed by: _____