CoreWorks Physical Therapy
11303 Wright Cir.
Omaha, NE 68144
Phone: 402-512-3237
Fax: 531-329-6837
www.coreworksphysicaltherapy.com

Patient Information

Today's Date_____ / _____ / _____ Birth date _____ / _____ / _____

Last Name _____ First Name _____MI _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip Code _____

Phone (Mobile) (____)_____ (Home) (___)_____ (Work) (_____)_____

Email _____

Employer _____ Occupation _____

Referring Physician Name _____ Date to return to Physician _____

Primary Physician _____ Primary Physician Phone (___)_____

How did you hear about CoreWorks Physical Therapy _____

Have you had previous physical therapy or chiropractic treatments this year? _____

Emergency Contact _____ Relation to patient _____

Emergency Contact Phone (_____)_____ Alternate Phone (____)_____

Please answer the following questions.

What are your goals for physical therapy? _____

_____

Past surgeries and/or hospitalizations and dates _____

_____

_____

Are you taking any medications? **Yes/No** If yes, please list medication name(s) and side effects.

_____

_____

Have you had any imaging performed?

☐ X-Ray, Date _____ ☐ Ultrasound, Date _____ ☐ CT Scan, Date _____
☐ MRI, Date_____ ☐ Doppler, Date _____

Do you know your resting blood pressure? ☐ Yes_____ mmHG ☐ No
Do you know your resting heart rate? ☐ Yes_____ beats/min. ☐ No

Are you pregnant? ☐ Yes ☐ No Have you had difficulties with any pregnancies? _____

_____

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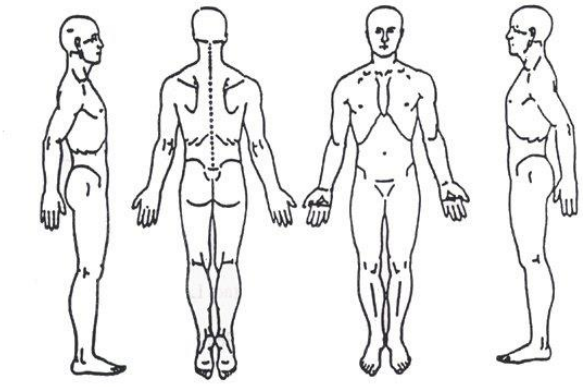
Do you currently have (or do you have a history of) any of the following?

	Yes	No	Unsure		Yes	No	Unsure
Allergy (including latex)				Leg Cramps			
Angina				Low Blood Pressure			
Asthma				Menstrual Irregularities			
Back Pain				Metal Implants			
Blackouts				Motor Vehicle Accident			
Bowel/Bladder Abnormalities				Nervousness			
Cancer				Neurological Disorder			
Chest Pain				Night Pain			
Convulsions				Osteoarthritis			
Depression				Osteoporosis			
Diabetes				Pacemaker			
Dizziness/Fainting				Paralysis			
EKG Abnormalities				Poor Tolerance To Heat/Cold			
Emphysema				Recent Fractures			
Gout				Rheumatoid Arthritis			
Headache				Ringing in ears			
Heart Attack				Seizures			
Heart Disease				Severe Illness			
Hernia				Sexual Dysfunction			
High Blood Pressure				Shortness of Breath			
Indigestion/Nausea/Vomiting				Skin Abnormalities			
Joint Pain				Sleep Interference			
Joint Sprains				Stroke			
Kidney Disease				Tuberculosis			
Ulcers				Other:_____			

Please indicate how you would rate your pain
If you have multiple areas, please write your pain rating next to the body part.

(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)



When and how did the pain begin? _____

_____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine
☐ Recreation ☐ Other _____

What activities cause pain? ☐ Sitting ☐Standing ☐ Walking
☐ Bending ☐Lying Down
☐ Other _____

What makes it feel better? _____
What makes it feel worse? _____

I certify to the best of my knowledge the above information I have provided is true and accurate.

_____ _____ _____
Signature Printed Name Today's Date