Cura Centers

☐ Canton Physical Therapy
65 Albany Tpke, Canton, CT 06019

☐ Winsted Physical Therapy
115 Spencer St, Winsted, CT 06098

☐ Main Street Physical Therapy
36 Main St, Torrington, CT 06790

☐ Windsor Physical Therapy
6 Poquonock Ave, Windsor, CT 06095

Name:_____ **Age**: _____ **Occupation**: _____

Next appt with referring doctor ____/_____/_____ **Height**: _____ **Weight:** _____lbs ☐**Right Handed** ☐**Left Handed**

☐AIDS/HIV	☐Breathing Problems	☐Hepatitis	☐Open Wound
☐Anemia	☐ Cancer	☐Herpes	☐Osteoporosis
☐Chest Pain	☐Depression	☐High Blood Pressure	☐Pacemaker
☐Aortic Aneurysm	☐ Diabetes	☐Infection	☐Polio
☐Arthritis	☐Dizziness/fainting/lightheadedness	☐Joint Replacement	☐Seizures
☐Asthma	☐Emphysema	☐Kidney Problems	☐Stroke
☐Blood Disorder	☐Fibromyalgia/Myofascial Pain Syndrome	☐Lyme Disease	☐Swelling of hands / feet
☐Bowel/Bladder Trouble	☐Heart Disease	☐Metal or Other Implants	☐Other_____

Medications (prescription, over the counter, & supplements): _____

Allergies ☐Bees ☐Strawberries ☐Shellfish ☐Lotions ☐Latex ☐Rubber ☐Tape ☐Cortisone ☐Other_____

Are you pregnant? YES NO **Weight gain/loss in last year?** (+-)_____lbs **Use Tobacco** YES NO **Alcohol** YES NO

List any surgeries, serious injuries, fractures, strains, dislocations that you have had **Date**

Injury:_____ **Date of injury**: ____/____/_____

How did current injury occur? _____ **Workplace or vehicle accident?** YES NO

Date of Surgery: ____/____/_____ **What procedure did you have done:** _____

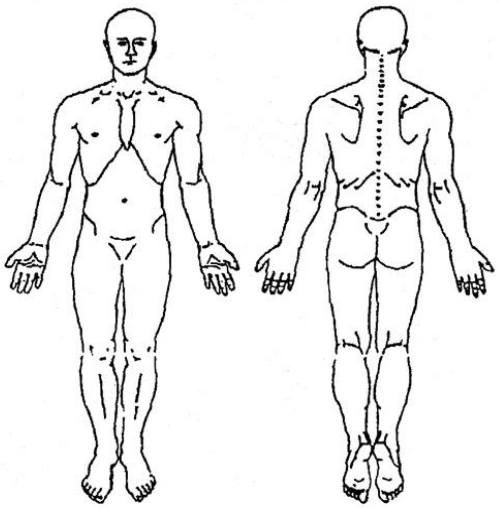
Have you had Physical Therapy in the past year for this injury? YES NO **Date of last visit**_____/_____/_____

Did you have: ☐X-Ray ☐MRI ☐CAT Scan ☐Other _____ **Does your:** ☐Knee give way ☐Knee lock up ☐Knee cap shift

Does your condition interfere with: ☐ House/Yard Work ☐ Job/Working ☐Reaching to the side or overhead ☐ In & out of car or tub ☐ Sleeping ☐ Walking up or down stairs ☐ Head movements ☐ Walking ☐ Standing ☐ Sitting ☐ Other: _____

Do you participate in sports, exercise or gym, or activities regularly: YES NO *Explain*_____

Mark on your body where you feel the described sensations. Include all affected areas even if they don't relate to this physical therapy visit.



Pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (high)

Is pain (all that apply) ☐Sharp ☐Dull ☐Intermittent ☐Constant ☐Deep ☐Shooting ☐Throbbing ☐Pinching ☐Tight ☐Burning ☐Diffuse

Condition began: ☐ Suddenly ☐ Gradually ☐ Trauma ☐ Chronic

Condition is: ☐Better ☐Worse ☐Same

What increases pain? _____

What decreases pain?_____

Pain with coughing or sneezing? YES NO

Daily activity: (none) 0 1 2 3 4 5 6 7 8 9 10 (high)

Rate your balance: (Poor) 1 2 3 4 5 6 7 8 9 10 (Good)

Have you had a significant fall in the last year? ☐ YES ☐ NO

Do you use brace: YES NO *Explain*_____

Are there any personal circumstances that may affect your physical therapy?_____

What do you hope to accomplish or gain from physical therapy?_____

Consent to Treatment: To the best of my knowledge, information provided herein is correct. I understand that I have been referred for rehabilitative treatment & care to Canton Physical Therapy. I understand my diagnosis and treatment plan will be discussed during my first appointment and I have the right to question and/or refuse any treatment prior to it being applied. By signing this agreement, I consent to have this facility provide treatment as prescribed by my physician and/or advised by my therapist.

Signature_____ Date_____