Randolph Health
Physical Therapy
& Sports Medicine

503 N. Fayetteville Street
Asheboro, NC 27203
Phone: 336-626-2688 Fax 336-626-6453

Name_____ Daytime phone #_____
Occupation:_____
Emergency Contact (name and phone number)_____

- Name of primary physician_____
- Name of referring physician_____
- When are you scheduled to return to your referring physician?_____
- Have you seen anyone else for your current condition?

☐ Physician/MD ☐Chiropractor ☐Podiatrist ☐Orthopedic Surgeon

☐Dentist ☐Neurologist ☐Physical Therapist ☐Other (specify: _____)

Past Medical History:
Have you ever had any of the following conditions? Check all that apply.

☐High blood pressure ☐Heart condition ☐Stroke ☐Osteoporosis

☐Peripheral Neuropathy ☐Seizures/epilepsy ☐Vision problems ☐Diabetes

☐Hearing problems ☐Fainting/dizziness ☐Emphysema ☐Frequent or severe headaches

☐Bowel/bladder problems ☐Cancer ☐Arthritis ☐Asthma ☐Hepatitis ☐HIV/AIDS ☐MRSA

☐ C-DIFF ☐Other:_____

Have you had any falls in the past year?	YES	NO	If so, about how many? _____
Do you have a history of fractures?	YES	NO	Where?_____
Do you have any metal implants?	YES	NO	Where?_____
Do you have a pacemaker?	YES	NO	
Do you have a defibrillator?	YES	NO	
Do you smoke?	YES	NO	How much per day?_____
Do you exercise regularly?	YES	NO	How often?_____
Do you have any known allergies?	YES	NO	Please list:_____
Are you pregnant or think that you might be?	YES	NO	

Medications:
Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking:

_____
_____

Surgeries: Please list all surgeries including dates:_____
_____

Diagnostic Tests: Please check any tests or procedures that have been done for your **current** condition.

☐X-rays ☐MRI ☐CT scan ☐Bone scan

☐EMG ☐Blood work ☐Bone density ☐Ultrasound

Current Condition

- What is the problem you are here for?_____
  _____
- What is the date when the problem started?_____
- Have you had similar symptoms before?_____
- Have you had previous treatment for this condition?_____

Patient Signature_____ Date_____

Therapist Signature_____ Date_____