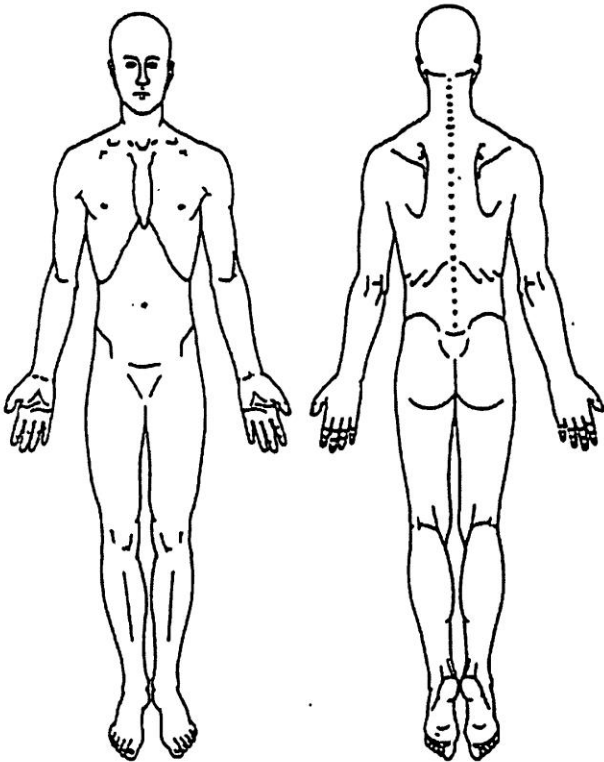
SIDNEY PhysioTherapy CLINIC

| NAME: |
|---|
| What problem (s) would you like addressed today? |

**Please mark the areas of your symptoms on the body to the left, and circle from 0 – 10 how bad the pain is at this moment**



| None | | | | | | | | | Worst |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

| What are your occupation and/or Hobbies? |
|---|
| Do you have any implants (i.e. pacemaker, artificial joints)? |
| Do you have any allergies? |
| Do you have any other medical conditions? |
| Please list your medications:<br>(Or bring a written list with you.) |

## Acknowledgment

I understand my diagnosis and plan will be discussed during my first appointment and that I have the right to question and/or refuse treatment prior to it being applied. Should my condition be related to a workplace injury or motor vehicle accident, I will accept responsibility for payment should coverage be denied by the third party payer.

| Date: | Patient Signature: |
|---|---|