

MINDY COHEN, MSPT, CST  
BURLINGTON, VT 05401

CLIENT INFORMATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

(PLEASE PRINT)

ADDRESS \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONES: WORK: \_\_\_\_\_ HOME: \_\_\_\_\_ CELL: \_\_\_\_\_

EMAIL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PATIENT RELATIONSHIP TO INSURED: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_ OTHER \_\_\_\_\_

PATIENT STATUS: EMPLOYED \_\_\_\_\_ FULL-TIME STUDENT \_\_\_\_\_ PART-TIME STUDENT \_\_\_\_\_  
SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ OTHER \_\_\_\_\_

NAME OF SPOUSE OR PARTNER \_\_\_\_\_

IS YOUR CONDITION RELATED TO (CIRCLE ONE):

- |                   |     |    |
|-------------------|-----|----|
| a. EMPLOYMENT     | YES | NO |
| b. AUTO ACCIDENT  | YES | NO |
| c. OTHER ACCIDENT | YES | NO |

EMPLOYER'S NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

DESCRIBE THE REASON YOU HAVE COME HERE AND THE SYMPTOMS YOU EXPERIENCING:

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DATE OF INJURY OR ONSET OF ILLNESS \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_

WHAT MAKES THE PROBLEM WORSE? \_\_\_\_\_

WHAT MAKES THE PROBLEM BETTER? \_\_\_\_\_

PAIN RATING 0-10 (0 = NO PAIN, 10 WORST PAIN IMAGINABLE) \_\_\_\_\_

WHAT OTHER TREATMENTS HAVE YOU RECEIVED FOR THIS PROBLEM? \_\_\_\_\_

LIST ALL MEDICATIONS: \_\_\_\_\_

LIST ANY ALLERGIES: \_\_\_\_\_

LIST AND DATE SURGERIES AND HOSPITALIZATIONS: \_\_\_\_\_

DATES AND TYPES OF LAST X-RAYS/CT SCANS OR MRI: \_\_\_\_\_

PLEASE INDICATE WHETHER YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS

- |                                                                  |     |    |
|------------------------------------------------------------------|-----|----|
| 1. VISION OR HEARING PROBLEMS                                    | YES | NO |
| 2. CARDIAC PROBLEMS (Heart attack, pacemaker, hi blood pressure) | YES | NO |
| 3. DIABETES                                                      | YES | NO |
| 4. CANCER                                                        | YES | NO |
| 5. THYROID PROBLEMS                                              | YES | NO |
| 6. LUNG PROBLEMS (asthma, bronchitis)                            | YES | NO |
| 7. LIVER OR KIDNEY PROBLEMS                                      | YES | NO |
| 8. PROBLEMS WITH THINKING OR MEMORY                              | YES | NO |
| 9. IF YOU ARE A WOMAN:                                           |     |    |
| a. ARE YOU PREGNANT?                                             | YES | NO |
| b. GYNECOLOGICAL INFECTIONS, CYSTS, FIBROMAS, IUD                | YES | NO |

IS YOUR CONDITION CAUSING DIFFICULTY WITH ANY ACTIVITIES LISTED BELOW? (PLEASE CIRCLE):

SITTING	STANDING	LAYING DOWN	WALKING	STAIRS	DRIVING
SLEEPING	LIFTING	HOUSEWORK	SELF-CARE	COOKING	SPORTS
WORK	SHOPPING	OTHER: _____			

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE ME TO KNOW? \_\_\_\_\_

WHAT DO YOU HOPE TO ACHIEVE FROM OUR WORK TOGETHER? \_\_\_\_\_

