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:_____

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:

____

____

____

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?_____________________________

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