Physical Therapy Center Of Greenpoint

Gerard Fiordalisi, P.T. D.P.T.

PATIENT NAME: ______________________________

DATE: ____________________

DO YOU HAVE NOW OR DO YOU HAVE A HISTORY OF:

ASTHMA	YES	NO
DIABETES	YES	NO
HEART CONDITION	YES	NO ______________
PACEMAKER	YES	NO
DIFFICULTY BREATHING	YES	NO ______________
CIRCULATION PROBLEMS	YES	NO ______________
OPEN WOUNDS, WHERE	YES	NO ______________
HIGH BLOOD PRESSURE	YES	NO ______________
UNDER CONTROL?	YES	NO
MEDICATION	YES	NO ______________
SENSITIVITY TO HOT OR COLD	YES	NO ______________
RHEUMATOID OR OSTEOARTHRITIS	YES	NO ______________
PSYCHIATRIC CARE	YES	NO ______________
PSYCHIATRIC DRUGS	YES	NO ______________
ANY IMPLANTS (JOIN REPLACEMENTS, ETC)	YES	NO ______________
HAVE YOU HAD PHYSICAL THERAPY BEFORE	YES	NO ______________

WHERE ____

WHY ____

RESULTS GOOD FAIR POOR

SIGNATURE: ____

8 McGuinness Blvd. South • Brooklyn, NY 11222 • Tel: 718-389-3131 • Fax: 718-389-0625