Maribeth Crupi Physical Therapy LLC
314 Main Street Unit 101
Wilmington, MA 01887
Phone: 978-447-5793
Fax: 978-447-5795

NPI# 146762703
MA License # 5468

DANCER INTAKE AND MEDICAL HISTORY

Name_____**Date of Birth:** _____ **Age:**_____ **Male / Female**

Current Problem:_____ **Date of Onset of Current Problem:**_____

Date of Surgery/Pending Surgery:_____ **Procedure:**_____

Address_____**City**_____**State**_____ **Zip**_____

Name of parent, spouse / significant other:_____

Email address:_____

Home Phone:_____ **Work Phone:**_____ **Cell:**_____

Primary MD:_____ **Ortho/Other MD:** _____

Employer / School Name and Phone: _____

Emerg. Contact and Phone_____**Referred by:** _____

Single or multi story home?_____ **Dance Studio/Company**:_____

Are you a Dance Student?_____ **Teacher?**_____ **Performer?**_____ **# Years Dancing?**_____

What styles of dance:_____ **Pointe: Y N Pre-Pointe: Y N**

Average # hours of dance per week: _____ **Greatest # hours dancing without a break in any one day**:_____

Dance is: (circle) **Fun/Recreational A goal for high school/college career path current professional**

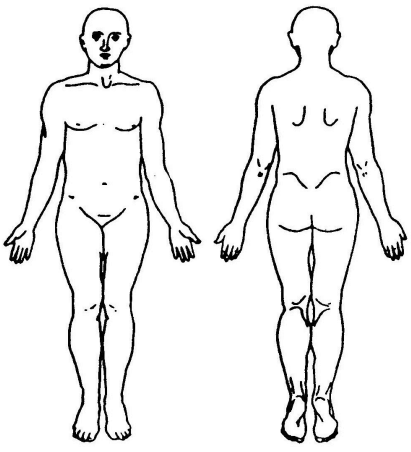
Note how many hours you dance next to the day: S_____**M**_____ **T**_____ **W**_____ **TH**_____ **F**_____ **S**_____

Other sports, activities:_____

Does your pain keep you from falling asleep? _____ **Does your pain wake you at night?**_____

Please rate your pain when it is at its worst on a scale of 0 (no pain) to 10 (worst possible):_____

Please use the following key to demonstrate your pain/symptom locations on the pictures below



Numbness ----------	Pins & Needles ^^^^^^^^
Burning xxxxxxxx	Sharp/Stabbing /////////
Cold 00000000	Achy))))))))
Throbbing zzzzzzzz	Other +++++++ (describe*)

**other*_____

How limited is your dancing? (please circle)

Not at all minimally moderately unable to dance

Which of the following provoke or increase your symptoms: (circle)

relevé plie landing from jumps cambres (back bends) turns

Other:_____

Do any of these activities increase your symptoms?: (please circle)

Sitting Walking Driving Kneeling Twisting: spine limb
Standing going up Stairs going down stairs Reaching Reclining/Laying flat
Lifting Bending Squatting Other:_____

Please describe any symptoms other than pain that you may experience with the above-circled activities:

_____

If your problem is at/near a joint, do you experience: (please circle) **popping locking cracking snapping**

What eases your symptoms? (please circle)
Heat Cold Medication Rest Change in position Other:_____

Is your condition overall (please circle): **Improving Getting Worse Staying the same**

Have you had any treatment for this current problem in the past? Yes No

Please describe_____

Have you had any of the following tests for this problem? (please circle)

XRay CT Scan Bone Scan EMG Nerve Conduction study MRI Other:_____
If yes to above, please bring any reports, images, etc. to your first appointment

Please circle any of the problems you have or have had in the past:

Diabetes	Bowel/Bladder Problems	Drug Allergies	Kidney Problems
Chest Pain	Urine Leakage	Allergies to Heat	Eating Disorders
High Blood Pressure	Asthma/Breathing Problems	Poor Cold Tolerance	Cancer
Heart Disease	Liver/Gallbladder Problems	Other Allergies	Surgeries
Heart Attack	Fractures (broken bones)	Hernia	Skin Abnormalities
Heart Palpitations	Hypoglycemia	Seizures	Irregular periods
Pacemaker	Special Diet Guidelines	Metal Implants	Nausea/Vomiting
Headaches	Rheumatoid Arthritis	Dizziness/Fainting	Sexual Dysfunction
Do you smoke now?_____	In the past?_____		Sprains

Other: _____ Are you menstruating? Y N Are your periods regular? Y N

If you circled any of the problems above, please explain briefly and give approximate dates of onset/occurrence:

Please list any medication you are taking:_____

Please fill in table below by indicating answer with check in the correct box and add narrative as needed.

Activity	Not Limited or N/A	Somewhat Limited	Very Limited	Unable to Do
Styling Hair				
Putting on footwear				
Sitting in school classes				
Doing chores at home				
Doing homework				
Driving a car				
Taking Dance Class				
Teaching Dance Class				
Sports				
Non-dance Work				
Other:				

What are you goals for physical therapy?_____

Signature_____ **Date:**_____
(Patient or parent/guardian if minor)