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

NPI# 146762703
MA License # 5468

INTAKE AND MEDICAL HISTORY

Name____**Date of Birth:** ____________ **Age:**_____ **Male / Female**

Problem:_________________________________**R**__ **L**__ **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:** __________________________

Do you work?_______ **Describe:**______________________________________**Single or multi story home?**__________

Please list any hobbies or sports and how frequently you participate:____

____

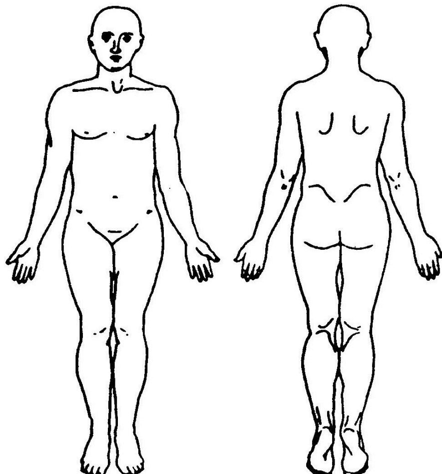
Do you participate in any other physical activities that may affect your problem?: _____________________________

If you have pain, please rate with a number as follows (0 is no pain and 10 is unbearable): ___________

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

On a scale of 0 to 10 with 10 being the worst pain imaginable, what would you rate your pain on average:________

Please use the following key to demonstrate your pain/symptoms on the pictures below:



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

Other:____

____

NAME:____

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

What activities increase your symptoms? (please circle)

Sitting	Walking	Driving	Kneeling	Twisting
Standing	going up Stairs	going down stairs	Reclining	Reaching
Lifting	Bending	Squatting	Rising	other:______________________

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

____

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)