Powerful Physical Therapy, PLLC
catpowell@powerfulpt.com
631-317-1222

Welcome to Powerful Physical Therapy! In order to ensure the best and safest treatment I will be asking a series of questions in regards to your medical history. Being thorough allows me to pick the most appropriate program and course of action to help get you back to doing things you love.

If you recently have had a significant injury/diagnosis (ie. surgery, a body part immobilized/casted, abnormal test result, etc.) please get medical clearance from your Doctor with any precautions or restrictions you might have with physical activity. *If you are unsure whether a symptom or test result applies to what you are receiving, simply ask! The body is more connected than you might think.

I, (please PRINT patient name)_____, acknowledge and understand that if I fail to provide accurate information, I am putting myself, and the therapist, at risk for injury or disease. I therefore am responsible for any harm I cause to myself or others.

Patient's signature _____

Date: _____

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Initial Examination Form

Name: _____ **D.O.B**_____
Phone Number:_____
Email:_____
Address:_____
City:_____ State:_____ Zip Code:_____

Primary Care Physician:
Name:_____ Phone Number:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Have you been seen by a medical provider already for your pain? Yes☐ No☐
☐ Primary Physician☐ Chiropractor☐ Orthopedic Surgeon☐ Dentist ☐ ER
☐ Nurse Practitioner☐ Acupuncturist☐ Physical Therapist☐ Other:_____

Emergency Contact:
Name:_____ Relationship:_____
Contact Information:_____

Occupation: _____
What do you work duties entail? (Check or highlight)
☐ Bending, ☐ Lifting, ☐ Sitting, ☐ Standing,☐ Walking, ☐ Crouching,
☐ Reaching,☐ Pushing, ☐ Pulling, ☐ Gripping,☐ Kneeling, ☐ Repetitive motion,
other:_____

Living environment:_____
Do you live alone?☐ Yes ☐ No If no, who do you live with:_____
Are you the primary caretaker or do you have support to help take care of you?_____

Does your home have:
☐ Stairs Outside: ☐ railing ☐ no railing ☐ Elevator
☐ Stairs Inside: ☐ railing ☐ no railing ☐ Uneven Terrain
☐ Ramps ☐ Other: _____

Do you have any workout equipment in your home? (ie. bike, treadmill, weights, yoga mat, straps, etc.)
_____

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General Health:
Please rate your health:
_☐_Excellent _☐_Good _☐_Fair _☐_Poor

Height_____Weight _____ Age _____

Do you use:
_☐_Cane
_☐_Walker or rollator
_☐_Manual Wheelchair
_☐_Motorized wheelchair
_☐_Other_____

Health Habits:
How much sleep, on average, do you get a night? _____
Diet:_☐_Excellent _☐_Good _☐_Fair _☐_Poor _☐_Am interested in learning more
Do you exercise regularly? _☐_ Yes _☐_No
If yes, how often and what type of activities?
_____
Other Hobbies/Recreational Activities?
_____
Are you able to fully participate in your work or leisurely activities?
_____
Have you had to make any changes in your daily routine due to pain or limitations?
_____

What are your goals for Personal Training/Wellness Sessions?

Any additional info/comments/concerns?

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Personal Past Medical History:

Have you previously had or currently have any of the following conditions:	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Cancer	☐	☐	Adhesive Allergy	☐	☐
High Cholesterol	☐	☐	Chemo/Radiation	☐	☐	Latex Allergy	☐	☐
Heart Attack	☐	☐	Anxiety/Depression	☐	☐	Osteoporosis	☐	☐
Arrhythmia (A-fib)	☐	☐	Multiple Sclerosis	☐	☐	Osteoarthritis	☐	☐
Pacemaker	☐	☐	Seizure/Epilepsy	☐	☐	Vascular Problem	☐	☐
Are you on blood thinners?	☐	☐	Parkinson's Disease	☐	☐	Stroke	☐	☐
Congestive Heart Failure	☐	☐	Cellulitis/Skin Disorders	☐	☐	COPD	☐	☐
Rheumatological Disorders	☐	☐	Pregnancy or Pregnant	☐	☐	Asthma	☐	☐
HIV/AIDs	☐	☐	Developmental Disorder	☐	☐	Diabetes Type I or II	☐	☐
Hepatitis	☐	☐	Joint Replacement	☐	☐	Smoking	☐	☐

Other Medical Conditions:	Surgical History:	Medications, Vitamins and/or Supplements Currently Taking:

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Reason for Personal Training/Wellness Sessions:
Where are your symptom(s) located? If you are experiencing more than one symptom, please provide information for all: _____
Have you had **any imaging/testing** done? If so what; _____
Are you currently being treated for your condition?_____

Have you ever been treated for this condition in the past_____
Is your injury related to a car accident?_____

Have you had surgery for your present condition? Yes ☐ No ☐
Type:_____ **DOS**_____

When did your symptom(s) begin?:_____
How did your symptom(s) begin?:_____

Please describe your symptom(s):

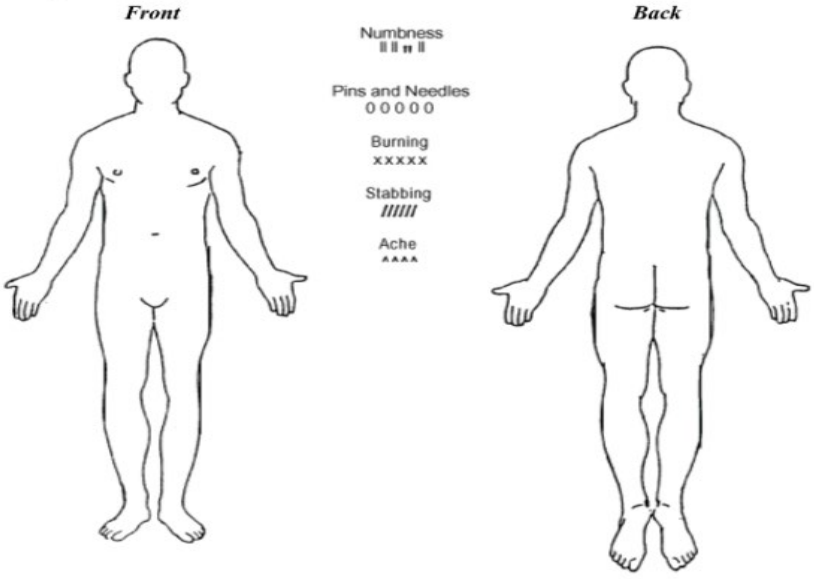
☐ Sharp ☐ Numb/Tingling ☐ Dull/Achy ☐ Radiating ☐ Stiff ☐ Other:

What makes you feel better?:_____
What makes you feel worse?: _____

Rate your symptoms from 0 to 10; 0 = No pain at all; 10= Worst pain, you need to go to the hospital

_____	_____	_____
Current	At Best (lowest #)	At Worst (Highest #)

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.



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Referral Information

How did you hear about Powerful Physical Therapy, PLLC?

If by a friend or family member, please give their phone number and address below so that I may send a thank you note.

Name_____

Address _____

City:_____ State: _____ Zip Code:_____

Phone Number_____

If you were referred by a Physician:

Physician name_____

Address _____

City:_____ State: _____ Zip Code:_____

Phone Number _____

Do you have a follow-up appointment with this physician?

Yes ☐ No ☐

If yes, when? _____

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Consent Form

I, _____, understand that I will be participating in a remote, online wellness and/or fitness program. These sessions may include traditional conservative treatments designed so that I can improve my strength, endurance, flexibility, balance, core strength, and overall health and wellness.

By signing below, I am giving my consent to take part in a wellness and/or fitness program at Powerful Physical Therapy, PLLC ("informed consent"). I also consent for sessions to occur in my home, gym, workplace, remotely, or any other location that has previously been agreed upon in writing prior to treatment.

The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition.

By signing below, I acknowledge that I have been instructed by Powerful Physical Therapy, PLLC to alert Powerful Physical Therapy, PLLC of any special needs, injuries, preferences, or considerations prior to starting the first session, as these could affect my safety and security during the exercise.

I understand that by signing below, I release Powerful Physical Therapy, PLLC of all liabilities for my health and safety during my participation in this wellness and/or fitness program. I further understand by signing below that, I release all employees of Powerful Physical Therapy, PLLC of personal liability. By signing below, I agree that if there are any disputes of liability that only Powerful Physical Therapy, PLLC may be sued. Further, if a suit is to take place the case must be filed in an Arbitration Court of New York within one year of participating at Powerful Physical Therapy, PLLC.

I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped or referred out to the proper practitioner. I reserve the right to withdraw at any time.

I agree to participate in remote training services.

Print Name: _____ Date: _____
Signature: _____

**Pen or electronic signature count, no pencil.