NewStride®
Physical Therapy

PLEASE ANSWER ALL OF THE FOLLOWING:

Briefly describe your injury: _____

Have you had surgery? _____Yes _____No If yes, when?_____

Are you taking medication for:

___Pain ___Diabetes ___Blood Pressure ___Cholesterol
___Heart ___Thyroid ___Vertigo ___Blood Thinner
Other:_____

On the scale below circle your worst pain level in the past week:

Mild 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10 Severe

Have you ever experienced heart problems, including heart surgery? _____Yes _____No

Do you have a pacemaker? _____Yes _____No

Have you ever tested positive for tuberculosis? _____Yes _____No

Do you have diabetes? _____Yes _____No

Do you have a history of seizures? _____Yes _____No

Do you have a history of dizziness? _____Yes _____No

Do you have a history of hypertension? _____Yes _____No

Do you have any joint or muscle problems or injuries? _____Yes _____No

Do you have neck problems including neck surgery? _____Yes _____No

What are your hobbies/sports?_____

Are you able to perform them at this point? _____Yes _____No

If employed, are you working at this time? _____Not employed

If yes: Light Duty_____ Modified Duty_____ Regular Duty_____

Were you seen by a physical therapist or a chiropractor regarding this injury before your doctor referred you to us? _____Yes _____No

If yes, how many weeks were you treated?_____

_____ _____

Signature Date