WONSETTLER
Physical Therapy & Specialized Health

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724-945-5164 (f)
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100 Wonsettler Road
Scenery Hill, PA 15360

Personal Details

First Name:_____ Last Name:_____

Date of Birth:_____ Gender: ○ Male ○ Female

Phone Number:_____ Email:_____

Street Address:_____

City:_____ State:_____ Zip code:_____

Emergency Contact:_____

Relation to Patient:_____ Emergency Contact Phone:_____

How did you hear about us? (check all that apply)

- ☐ Returning patient
- ☐ Google
- ☐ Facebook or other social media
- ☐ Radio
- ☐ Newspaper
- ☐ Drive by / Signage
- ☐ Healthcare provider
- ☐ Word of Mouth (please tell us who)

  _____

  _____
- ☐ Other

  _____

Current Problem

Do you have a Primary Care Physician?_____

Who is your referring provider?_____

Please describe the current problem you are seeking treatment for:_____

_____

_____

When did you first experience symptoms related to your issue:_____

Have you received treatment or surgery following the initial problem? ◯YES (please describe) ◯NO

_____

Is this issue work related?◯YES ◯NO Is this issue auto related?◯YES ◯NO

_____

Any imaging? (X-ray, MRI etc)_____

_____

_____

How do you currently manage your problem?_____

_____

_____

Current exercise activity level? (select one) ◯ Sedentary ◯ Moderate ◯ Very Active

How many days per week do you exercise:_____

Describe your typical sleep patterns:_____

Smoking/tobacco use? ◯YES ◯NO Alcohol consumption? ◯YES ◯NO

Describe your typical use:_____

Medical History

Past/current problems

- ☐ None
- ☐ Addiction
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ History of Cancer
- ☐ Colon Disease
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ CVA/TIA (stroke)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Dizziness
- ☐ Heart Attack
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy

☐ Other:_____

_____

_____

Previous surgery or injury list (please date when possible): _____

_____

_____

_____

Medications/Vitamins/Supplements List:_____

_____

_____

_____

Are there any ALLERGIES or other SENSITIVITIES we should be aware of?_____

_____

_____

Patient Goals

Please select as many goals as you would like

- ☐ Return to normal mobility
- ☐ Improve overall strength
- ☐ Reduce pain to improve overall function
- ☐ Sit for prolonged period without pain
- ☐ Stand for prolonged period without pain
- ☐ Perform stairs with improved function
- ☐ Walk long distances without pain
- ☐ Stand out of a chair more easily
- ☐ Get off of floor more easily
- ☐ Sleep without problems or pain
- ☐ Dress independently
- ☐ Improve lifting/carrying capacity
- ☐ Improve upper body function
- ☐ Reduce dizziness

Do you have any specific goals? Please describe them in detail here:

_____

_____

_____

_____

Can you identify any potential obstacles to reaching your goals?

_____

_____

_____

_____

What do you LOVE to do? Are you currently engaging in those activities? With any restrictions?

_____

_____

_____

_____