



# Wonsettler Physical Therapy & Specialized Health

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 724-200-7343  
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 100 Wonsettler Rd.  
 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? (circle 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

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

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

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

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Can you identify any potential obstacles to reaching your goals?

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

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