SNOW SPORT & SPINE

Katie Snow, PT, DPT, CLT
Trevor Mills, PT, OCS, CSCS
Christina Kelly, PT
Felicia Files, PTA, LMT
team@snowsportandspine.com
P.O. Box 802 • Rockport, ME 04856 • PHONE 207 230 0700 • FAX 207 517 2097

ORTHOPAEDIC MANUAL THERAPY CENTER

Patient Registration

Name (First):	Last:	DOB:
Cell Phone:	Alternate Phone:	
Address:		
City:	State:	Zip:
E-mail:		

Employer: _____ Occupation: _____

Emergency Contact:	Phone:
Relation:	

What is your reason for attending physical therapy: Cause of injury or onset?

Name of referring physician:
How did you hear about us:

Was this: Auto Related ☐ Work Related ☐ Date of Onset/Accident: _____

If these is related to an auto accident or worker's compensation claim, then additional forms and information will be necessary before treatment can begin.

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Concussion Questionnaire

Name:	Date:

Answer Yes or No to the following questions

☐ Yes ☐ No Do busy environments cause you to feel foggy, dizzy, or tired?

☐ Yes ☐ No Do you become dizzy looking up/down, turning head, or when standing quickly?

☐ Yes ☐ No Are you experiencing car sickness?

☐ Yes ☐ No Does moving quickly make you dizzy?

☐ Yes ☐ No Do you have a history or family history of anxiety?

☐ Yes ☐ No Do you take inventory of your symptoms? How often?

☐ Yes ☐ No Do you have difficulty turning off your thoughts?

☐ Yes ☐ No Do you have difficulty falling asleep?

☐ Yes ☐ No Do you feel a frontal pressure in your head/behind your eyes with reading/computer work/taking notes in class?

☐ Yes ☐ No Do you have blurred or fuzzy vision while reading or difficulty reading?

☐ Yes ☐ No Are you having significant difficulty with Math and/or science?

☐ Yes ☐ No Do you have a generalized headache that increases as day progresses?

☐ Yes ☐ No Do you feel more fatigued than normal at the end of the day?

☐ Yes ☐ No Do you feel more distractible in school/work than normal?

☐ Yes ☐ No Did you get migraines before your injury?

☐ Yes ☐ No Do you have a family history of migraines?

☐ Yes ☐ No Is your sleep dysregulated?

☐ Yes ☐ No Are you experiencing more stress than normal?

☐ Yes ☐ No Does your neck hurt? Is it stiff?

☐ Yes ☐ No Do you have a headache mostly in the morning?

Medical History

To ensure you receive a complete and thorough evaluation, please provide us with your health history information. If you are not sure how to answer a question, please leave it blank and your therapist will assist you.

Date of last physical exam:

Please mark any of the following practitioners you see:

☐ Medical Doctor ☐ Psychiatrist/Psychologist ☐ Optometrist
☐ Osteopath ☐ Physical Therapist ☐ Massage Therapist
☐ Dentist ☐ Chiropractor ☐ Acupuncturist
Other (Please list): _____

If you have seen any of the above during the last three months, please describe for what reason (illness, medical condition, annual exam, etc.)

Please list any surgeries or conditions, including approximate dates, for which you have been hospitalized.

Please describe any significant injuries for which you have been treated, including approximate date (fractures, dislocations, sprains, trauma, etc.).

Please list any medications and supplements you are taking (prescribed & over the counter)

During the past month have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Have you recently noted any of these symptoms (check all that apply)?

- ☐ Weight loss/gain
- ☐ nausea/vomiting
- ☐ dizziness
- ☐ fatigue
- ☐ weakness
- ☐ fever/chills/sweats
- ☐ numbness/tingling
- ☐ tremors
- ☐ seizures
- ☐ double vision
- ☐ loss of vision
- ☐ eye redness
- ☐ problems sleeping
- ☐ sexual difficulties
- ☐ night sweats
- ☐ hearing problems
- ☐ joint/muscle swelling
- ☐ easy bruising
- ☐ excessive bleeding
- ☐ difficulty breathing
- ☐ regular cough
- ☐ arm/leg swelling
- ☐ skin rash
- ☐ anxiety
- ☐ heart racing in chest
- ☐ difficulty swallowing
- ☐ heartburn/indigestion
- ☐ constipation/diarrhea
- ☐ blood in stools
- ☐ stress
- ☐ problems urinating
- ☐ urinary incontinence
- ☐ blood in urine
- ☐ currently pregnant
- ☐ post-menopausal

Describe your general health:

What are your overall health and wellness goals?

Do you use a computer at work? ☐ Yes ☐ No

Approximately how many hours do you spend a day in front of a screen?

Do you exercise regularly? ☐ Yes ☐ No
What types of exercise do you do and how often?

How many hours of sleep do you get a night?
How would you rate the quality of your sleep?

Do you live a high-stress lifestyle? ☐ Yes ☐ No
How do you manage stress?

Do you eat a healthy diet? ☐ Yes ☐ No
How would you rate your diet?

How many cups of caffeinated beverages (coffee, soda) do you drink per day?

Do you use tobacco? ☐ Yes ☐ No If "No", have you ever used tobacco? ☐ Yes ☐ No

If yes, what type of tobacco do you use? If quit, when did you quit?

How much do you use per day?

How long have you been using tobacco?

Do you drink alcohol? ☐ Yes ☐ No How often? How much?

Have you EVER been diagnosed as having any of the following conditions (check all that apply)?

☐ Cancer	What Kind:
☐ Heart Problems	What Kind:
☐ Circulation Problems	What Kind:
☐ Kidney disease	What Kind:

☐ High blood pressure
☐ Asthma
☐ Stomach ulcers
☐ Chemical Dependency (ie, alcoholism)
☐ Thyroid Problems
☐ Diabetes
☐ Lyme Disease
☐ Rheumatoid Arthritis
☐ Anxiety
☐ Depression
☐ Hepatitis
☐ Tuberculosis
☐ Stroke
☐ Blood Clots
☐ Osteoporosis/Osteopenia
☐ Multiple Sclerosis
☐ Other arthritic conditions
☐ COVID-19

Other:

Family History

Has anyone in your immediate family ever been treated for the following (check all that apply)?

☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ Stroke
☐ Inflammatory arthritis (rheumatoid, ankylosing)
☐ Chemical dependency
☐ Depression
☐ Kidney disease
☐ Cancer

Because of your problem/injury, what specific activities are you having difficulty with?

What are your personal goals/outcomes you hope to achieve from physical therapy?

Have you had prior physical therapy or other care for this condition? ☐ Yes ☐ No
What was done and what were the results?