Maccio Physical Therapy, PLLC
Joseph G. Maccio, PT Dip. MDT
Joseph R. Maccio, DPT, Dip MDT
Lindsay Carlton, ATC, DPT, Dip. MDT
Matthew Myers, DPT
Certified McKenzie Spine and Extremity Clinic

1 New Hampshire Ave.
Troy, NY

(518) 273-2121

Returning Patient Questionnaire

Are you currently receiving **Home Health Care**? Y / N

Are you currently receiving **Speech Therapy**? Y / N

Have you or are you currently receiving **Chiropractic Care** this year? Y / N

Have you had previous **Physical Therapy** by any other provider in the last year? Y / N

Is this injury Work-related or Motor vehicle-related? Y / N If yes: Date of Injury:_____

Primary Care Physician _____ Referring MD: _____

If your address, insurance, or phone number has changed please notify the front desk. You may use the back of this paper to record any changes.

I acknowledge the above information is correct to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

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General Medical History

Name: _____ Referring Physician: _____
Emergency contact: _____ Relationship: _____
Contacts home phone: _____ Contacts work phone: _____
Please circle if you are allergic to any of the following: Chlorine Iodine
Other allergies: _____
Current Medications (include dosage): _____
_____

What is the average intensity of your symptoms?

Please circle any of the following which applies to you. Please explain any circled responses in the space below.

Arthritis	Headache	Pins and Needles
Asthma	Hearing Difficulties	Pneumonia
Blood Disorders	Heart Attack	Pregnant (Currently)
Cancer	Hepatitis	Seizures
Chest Pain	High/ Low Blood Pressure	Sprain / Strain
Cyanosis	High / Low Pulse	Stroke
Diabetes	HIV+/ AIDS	Swelling
Dizziness	Inhaler	TB
Emphysema	Joint Pain	Tremor
Faint Feeling	Joint Replacement	Varicosities
Fracture	Numbness	Visual Problems
Gastrointestinal	Pace Maler	Weakness
Genito-Urinary	Paralysis	Other: _____

EXPLANATIONS:_____
_____

I acknowledge that the above information is correct to the best of my knowledge.

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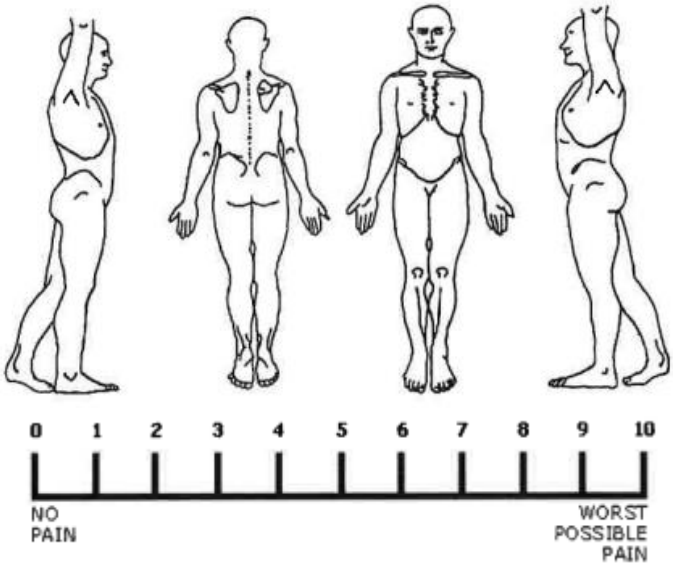
How are you feeling today?

Patient Name: _____ Date: _____

1. **Describe your Symptoms**:_____
   _____
   a. **When did your symptoms start?** _____
   b. **How did your symptoms start?** _____
2. **How Often do you experience your symptoms?**
   a. Constantly (76-100% of the day)
   b. Frequently (51-75% of the day)
   c. Occasionally (26-50% of the day)
   d. Intermittently (0-25% of the day)
3. **What is the nature of your symptoms?**
   a. Sharp d. Shooting
   b. Dull Ache e. Burning
   c. Numb f. Tingling
4. **How are your symptoms changing?**
   a. Getting Better
   b. Not Changing
   c. Getting Worse
5. **During the last 4 Weeks indicate the average intensity of your symptoms on the scale:**

Indicate on the diagrams where you have pain or other symptoms



6. **During the past 4 weeks how much has pain interfered with your normal work? (Outside of the home and household)**
   a. Not at All b. A Little Bit c. Moderately d. Quite a Bit e. Extremely
7. **What are you unable to do because of your current condition?**
8. **To what degree is this important to you?**
9. **How does this condition affect your livelihood?**
10. **Do you think physical therapy can help you?**
11. **What results do you hope to see from physical therapy?**

For Medicare Patients Only

1. **Have you had 2 or more falls in the past year?**
   Yes No
2. **Have you had any falls resulting in injury?**
   Yes No

Therapist Initials_____
Date_____