



1 New Hampshire Ave.  
Troy, NY

## Maccio Physical Therapy, PLLC

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

(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?

Indicate on the diagrams where you have pain or other 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

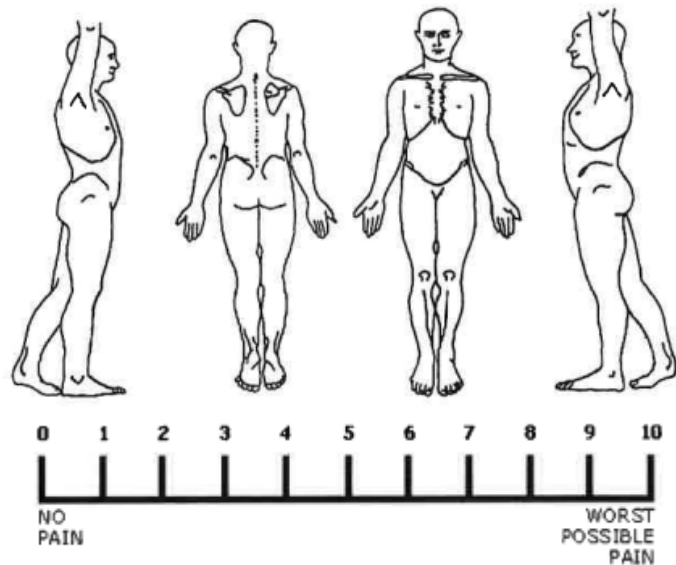
4. How are your symptoms changing?

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:



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 \_\_\_\_\_