736 Cayuga Street
Lewiston, NY 14092
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NiagaraPT.com

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Referring Physician (If Any): _____

Next appointment with Referring Physician: _____

How did you hear about our office? _____

Is there anyone we can thank for your referral other than your doctor? _____

Medical History

Have you experienced this condition in the past? ☐ Yes ☐ No If Yes, When? _____

Have you received any other treatments for your current condition? (Home Therapy, Chiropractic, Massage, Injections, etc..)

If Yes, what type and when? _____

Have you had any related surgeries? ☐ Yes ☐ No

If Yes, what type and when? _____

Please check if you currently have or ever had any of the following:

☐ Arthritis	☐ Osteoporosis	☐ Broken Bones/ Fractures	☐ Skin Diseases
☐ High Blood Sugar	☐ Low Blood Sugar	☐ Diabetes	☐ Infectious Disease
☐ Seizures	☐ Epilepsy	☐ Depression	☐ Thyroid Problems
☐ High Blood Pressure	☐ Stroke	☐ Circulation	☐ Kidney Problems
☐ Parkinson's Disease	☐ Muscular Dystrophy	☐ Multiple Sclerosis	☐ Blood Disorders
☐ Head Injury	☐ Allergies	☐ Ulcers/Stomach Problems	☐ Lung Problems
☐ Cancer	☐ Heart Problems	☐ Pacemaker/Defibrillator	☐ Asthma

☐ Other Precautions: _____

Please describe any of the above checked boxes: (types, dates, etc.)

_____

_____

_____

Medication List: (Please include over the counter medications and/or supplements. You may provide a list for our office to copy.)

Drug	Dosage	How often	Reason