OAKLAND PHYSICAL THERAPY, PA
Orthopedic and Sports Rehabilitation

Dr. Robert Freund, DPT
43 Yawpo Ave, Suite 10 Oakland, NJ 07436

Return Patient Form

Physician Information:

Referring Physician: ____________________________________ Phone: __________________

Address: ______________________________________ Fax: _____________________________

Current Complaint:

Briefly describe the reason for your visit: ____

____

Date Symptoms Began: ________________ How did your problem start? __________________

____

Have you had surgery for this condition? Y ☐ N ☐ Date of Surgery (if applicable): ___________

What makes problem: Worse? _________________________ Better? ___________________

Have you had any diagnostic testing? X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Other ☐

What were the results? ____

What is your AVERAGE or TYPICAL symptom level?

None ←---- 0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ----10 ----→ Worst imaginable

Have you ever had this symptom or injury before? Y ☐ N ☐

If yes, explain treatment and outcome: ____

Please list any PRESCRIPTION medications you are taking: ______________________________

____

Please list any OVER- THE –COUNTER medications you are taking: _______________________

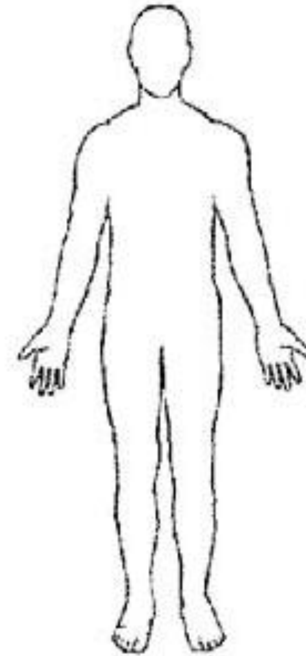
____

Signature: ____ Date: ______________________

Name: ____

Current Symptoms-

Assessment Chart

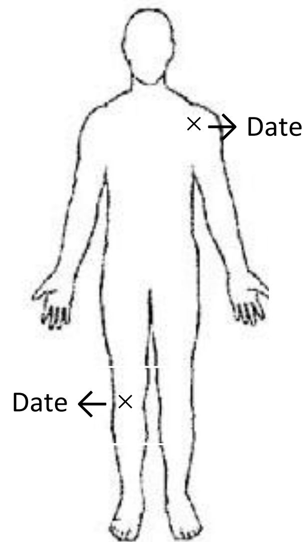


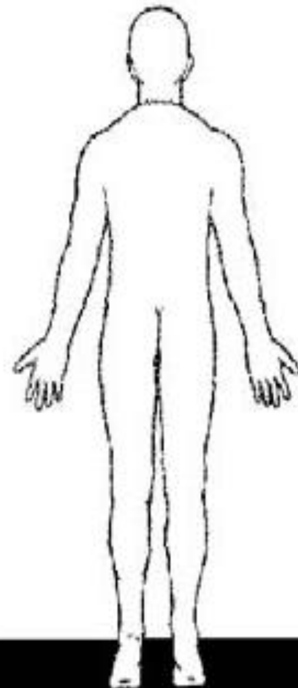
Instructions:

1. Place an "X" on each area of the body diagram where you are feeling symptoms.
2. Write the date each area of symptoms started for this episode, to the best of your memory.

This list provides some examples of words that may help describe your symptoms. Check all that apply.

___ Sharp ___ Shooting
___ Burning ___ Dull
___ Ache ___ Tingling
___ Heavy ___ Tight
___ Throbbing ___ Numb
___ Pulling ___ Stabbing





This list provides words that may help describe the behavior of your symptoms. Check all that apply.

___ Constant (never goes away)
___ Intermittent (relieved in some positions or at rest)
___ Variable (sometimes worse than other times)
___ Unchanging (always the same)
___ No symptoms

How are your symptoms progressing recently?

___ Improving
___ Worsening
___ Staying the Same

Patient Signature: ____ Date: _______________________

Have you ever had any of the following? *(Please check Y or N)*

Y ☐ N ☐ Angina/ Chest Pain
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Kidney Disease
Y ☐ N ☐ Anemia
Y ☐ N ☐ Stroke
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Depression
Y ☐ N ☐ Asthma
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Multiple Sclerosis
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Thyroid Problems
Y ☐ N ☐ Pacemaker
Y ☐ N ☐ Emphysema
Y ☐ N ☐ HIV/ AIDS
Y ☐ N ☐ Rheumatoid Arthritis
Y ☐ N ☐ Other Arthritic Conditions
Y ☐ N ☐ Circulation Problems

If you checked yes for any of the above conditions, please explain: _________________________

____

Y ☐ N ☐ Heart Disease/ Heart Attack: If yes, describe______________________________________

Y ☐ N ☐ Cancer: If yes, what type? ____

Y ☐ N ☐ Chemical Dependency (e.g. Alcoholism): If yes, describe ____________________________

Y ☐ N ☐ Allergies: If yes, list ____

In the past three months, have you experiences any of the following? *(Please check Y or N)*

Y ☐ N ☐ Fever/ Chills/ Sweats: If yes, describe ____

Y ☐ N ☐ Unexplained weight change: If yes, describe _______________________________________

Y ☐ N ☐ Fatigue: If yes, describe ____

Y ☐ N ☐ Nausea/ Vomiting: If yes, describe ____

Y ☐ N ☐ Changes in bowel/ bladder function (difficulty, frequency, etc) If yes, describe _______

____

Y ☐ N ☐ Dizziness/ Lightheadedness: If yes, describe ______________________________________

Y ☐ N ☐ Numbness/ Tingling: If yes, describe ____

Y ☐ N ☐ Shortness of breath: If yes, describe ____

What is your current Height: _________________ Weight: ________________

Signature: _________________________ Name: _______________________________Date: _____________