Encompass Physical Therapy, LLC

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Annapolis, MD 21401
Ph: 410-266-1500 Fax: 410-266-1369

Please Print Legibly In Black Ink

Name: ___________________________ Birthdate: ____/____/_______ Sex: M or F

Do you want to receive appointment reminders by email? Yes No

Primary Phone: ______________________ H/W/C Secondary: ____________________ H/W/C

Referring Physician:______________________________

Chief Complaint: _________________________________Date of Injury: ____/___/______

Circle Current Symptoms: Pain Numbness Stiffness Weakness Chronic Acute

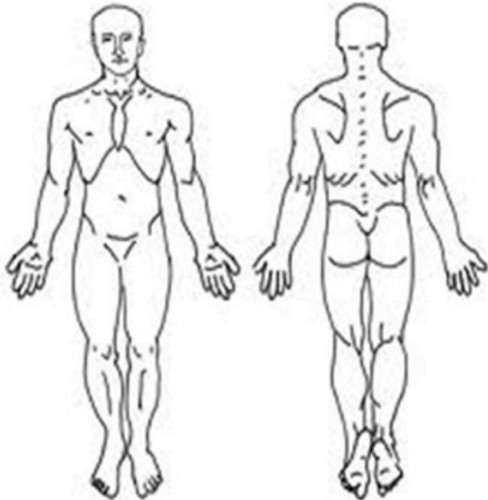
Occupation: ________________________ Is this injury? ☐ Work related ☐ Auto accident

List all medications you currently are taking: ____

Have you had any of the following medical services for this injury? ☐ MRI ☐ XRAYS ☐ CT SCAN

Height:______________ Weight:_______________

Use **X** marks to show
where you feel pain TODAY



0-10 Pain Rating Scale
Please circle

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Worst pain

Medical History/Evaluation

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO
Asthma, Bronchitis, Emphysema	☐	☐
Shortness of breath/Chest pain	☐	☐
Coronary Heart Disease	☐	☐
Do you have a pacemaker?	☐	☐
High blood pressure	☐	☐
Heart attack	☐	☐
Stroke/ TIA	☐	☐
Epilepsy/Seizures	☐	☐
Thyroid trouble/Goiter	☐	☐
Anemia	☐	☐
Infectious Disease	☐	☐
Diabetes	☐	☐
Cancer or Chemo/Radiation	☐	☐
Arthritis/Swollen joints	☐	☐
Osteoporosis	☐	☐
Varicose veins	☐	☐
Gout	☐	☐
Emotional/Psychological problems	☐	☐
Bowel or bladder problems	☐	☐
Severe/frequent headaches	☐	☐
Dizziness or Faintness	☐	☐
Alcohol consumption	☐	☐
Blood clot/Emboli	☐	☐
Are you pregnant?	☐	☐
Do you smoke?	☐	☐

Other medical conditions: _________________
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