Lago Vista Physical Therapy
5802 Thunderbird St, Suite A
Lago Vista, TX 78645
Phone: (512) 267-5400 Fax: (512) 267-5700

New Patient Form

Patient Name: ____ Date of Birth ____/____/______ Today's Date ____/____/_____

Street Address: ____

City/State/Zip____ Social Security Number: __________________________

Home Phone: ____ Other Phone: ______________________________________

Emergency Contact: ____ Phone number: ________________________

Date Symptoms Began: ____/____/______ **Date of Injury:** ____/____/______ **Date of Surgery:** ____/____/______

Referring Physician: ____

Have you received Diagnostic Testing for this injury/surgery/problem? Yes or No Facility: ___________________________

Have you ever received home health services? Yes or No.
If yes, Discharge Date: ____/____/_____ Home Health Agency____________________

Have you received Physical Therapy anywhere this year? Yes or No
If yes, Approximate date range: _________________________, Name of Facility: _______________________

Briefly describe your symptoms for todays visit: ____

How did your symptoms start? ____

Average Pain Intensity

Last 24 Hours:	no pain	1	2	3	4	5	6	7	8	9	10	worst pain
Past Week:	no pain	1	2	3	4	5	6	7	8	9	10	worst pain

How often do you experience your symptoms?

1- Constantly (76%-100% of time) 2- Frequently (51%-75% of time)

3-Occassionally (26%-50% of time) 4- Intermittently (0%-25% of time)

How much have your symptoms interfered with your usual daily activities? (Including both work outside the home and housework)

1- Not At All 2-A Little Bit 3- Moderately 4- Quite A Bit 5- Extremely

How much is your condition changing, since care began at *this* facility?

0- N/A-Initial visit 1-Much worse 2-Worse 3-A Little Worse 4-No Change 5-A Little Better 6-Better 7-Much Better

In general, would you say your overall health right now is…
1-Excellent 2-Very Good 3-Good 4-Fair 5-Poor

Patient Signature: **X**____ Date ____/____/_____