PATIENT INFORMATION

(OVER→)

NAME: FIRST_____ LAST_____ DATE OF BIRTH_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PHONE: ( )_____ CELL: ( )_____ HEIGHT: _____ WEIGHT: _____

EMERGENCY CONTACT NAME_____ PHONE _____
RELATIONSHIP _____

HAVE YOU HAD ANY PHYSICAL THERAPY TREATMENT THIS YEAR? Y N HOW MANY? ____
HAVE YOU HAD ANY CHIROPRACTIC TREATMENT THIS YEAR? Y N HOW MANY? ____

PHYSICIAN WHO REFERRED YOU TO PHYSICAL THERAPY_____
NEXT APPOINTMENT WITH PHYSICIAN WHO REFERRED YOU _____
PRIMARY CARE PHYSICIAN _____

EMPLOYMENT INFORMATION

EMPLOYER NAME _____ OCCUPATION _____
EMPLOYER ADDRESS _____ WORK PHONE _____
CITY, STATE, ZIP _____ DID INJURY OCCUR AT WORK? Y N

DID INJURY OCCUR IN AN AUTO ACCIDENT? Y N DATE OF ACCIDENT ____/____/____
STATE IN WHICH ACCIDENT OCCURRED _____

RESPONSIBLE PARTY

NAME _____
ADDRESS _____
DATE OF BIRTH ___/___/___DAYTIME PHONE _____
PLACE OF EMPLOYMENT _____

INSURANCE

PRIMARY INSURANCE:_____ NAME OF INSURRED:_____
INSURRED DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____
ID NUMBER:_____ GROUP NUMBER:_____
SECONDARY INSURANCE:_____ NAME OF INSURRED:_____
INSURRED DATED OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____
ID NUMBER:_____ GROUP NUMBER:_____

WORKERS COMPENSATION PATIENTS

CLAIM NUMBER _____ DATE OF INJURY ____/____/____
NAME OF EMPLOYER AT TIME OF INJURY? _____
ADDRESS OF EMPLOYER IF THEY ARE SELF INSURED _____

I agree to pay medical costs in the event of failure to prosecute the claim for Worker's Compensation or if the compensation claim is disallowed.

SIGNATURE OF INJURED WORKER_____DATE___/___/___

(OVER→)

PATIENT MEDICAL HISTORY

Tell Us About You:

Name: _____

Why were you referred to physical therapy? Please describe how and when your injury occurred.

_____

_____

What do you want to accomplish from therapy? _____

In the last year, have you undergone any surgical procedures? ☐ YES ☐ NO

In the last year, have you been admitted to a hospital? ☐ YES ☐ NO

What was the condition/surgery? _____

Have you received any physical therapy treatment during the past year? ☐ YES ☐ NO

If yes, for what condition? _____ Where? _____

Have you fallen in the past 12 months? ☐ YES ☐ NO If yes, number of times: _____

★ If you have fallen in the past 12 months, how did you fall? _____

If you fell did you injure yourself and what was the injury? _____

Tell Us About Your Activities at Work and Home...

Occupation: _____

Hobbies/Sports & Exercise: _____

At the present time, what are the most difficult tasks for you to perform? _____

At WORK: _____

At HOME: _____

Have You Been Concerned With Any of the Following:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Pacemaker	☐	☐	Exposure/Treatment TB	☐	☐
Heart Condition	☐	☐	Seizures	☐	☐	Cough for > 2 weeks	☐	☐
Numbness	☐	☐	Cancer	☐	☐	Fever for > 2 weeks	☐	☐
Neurological	☐	☐	Skin	☐	☐	Unexplained Weight Loss	☐	☐
Diabetes	☐	☐	Weight	☐	☐	Pregnancy	☐	☐
Dizziness	☐	☐	Bladder Control	☐	☐	Digestion	☐	☐
Mental Health	☐	☐	Bowel Control	☐	☐	Immune System	☐	☐

Circle any special tests related to your injury/condition:
CT-scan, EMG, ECG, MRI, X-Rays, Tilt Table, VNG, Bone Scan

★ Please list your medications (include dosage): _____

_____

_____

Patient/Guardian Signature: _____ Date: _____

Reviewed with Patient: _____ Date: _____

Therapist Signature