ACROSS ALL AGES
PHYSICAL THERAPY, LLC
380 S Germantown Rd, Breese, IL 62230
Phone: 618-526-9311 ● Fax: 877-420-7862

PATIENT INFORMATION

Today's Date: _____ Name: _____ D.O.B.: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

Married: ____ Single: _____ Divorced: _____ Widowed: _____ ☐ Male ☐ Female

Employer/School: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____ Fax #: _____ Next Visit: _____

Specialist Physician: _____ Phone: _____ Fax #: _____ Next Visit: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Person Responsible for Payment: _____ D.O.B. _____

How did you hear about us? _____

PATIENT HISTORY

Chief Complaint/Diagnosis: _____ Date of Onset: _____ Surgery Date: _____

Is this a work related injury? ☐Yes ☐No Occupation: _____ Return date to M.D.: _____

Current smoker or tobacco user? ☐ Yes ☐ No Female: Are you pregnant or any chance you could be? Y N

What test/treatments have you had for this problem? (Check appropriate boxes):

☐	X-Ray	☐	Physical Therapy	Imaging Results:	_____
☐	MRI	☐	Chiropractor		_____
☐	CT Scan	☐	Injections		_____
☐	Bone Scan	☐	Nerve Test (EMG/NCV)	☐ Other:	_____
☐	Ultrasound	☐	Previous surgery for this problem		_____

Any special instructions or restrictions from your doctor? ☐ No ☐ Yes (If yes, please explain): _____

What are your goals for therapy?

☐	Decrease pain	☐	Increase flexibility/ROM	☐	Return to sport
☐	Increase strength	☐	Go back to work	☐	Learn exercises for home

Other (please specify): _____

Current Medications (including over-the-counter and vitamins) or see attached list: _____

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SYMPTOM REVIEW

Have you **RECENTLY EXPERIENCED** any of these symptoms? Please check all that apply.

SKIN
- ☐ Frequent Rashes
- ☐ Open Wounds

EYES
- ☐ Blurred Vision
- ☐ Double Vision

LUNGS
- ☐ Shortness of Breath
- ☐ Chronic Cough

ENT
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Difficulty Swallowing

BONES/JOINTS
- ☐ Swelling/Redness

DIGESTIVE
- ☐ Nausea/Vomiting
- ☐ Changes in Bowel Habits/Control

NEUROLGICAL
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Weakness
- ☐ Frequent Falls
- ☐ Dizziness/Lightheadedness or Fainting
- ☐ Loss of Coordination

KIDNEY/BLADDER
- ☐ Kidney Problems
- ☐ Urinary Infections
- ☐ Changes in Bladder Habits/Control

GENERAL
- ☐ Weight Loss/Gain
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Pain at Night

CARDIAC
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Calf Pain

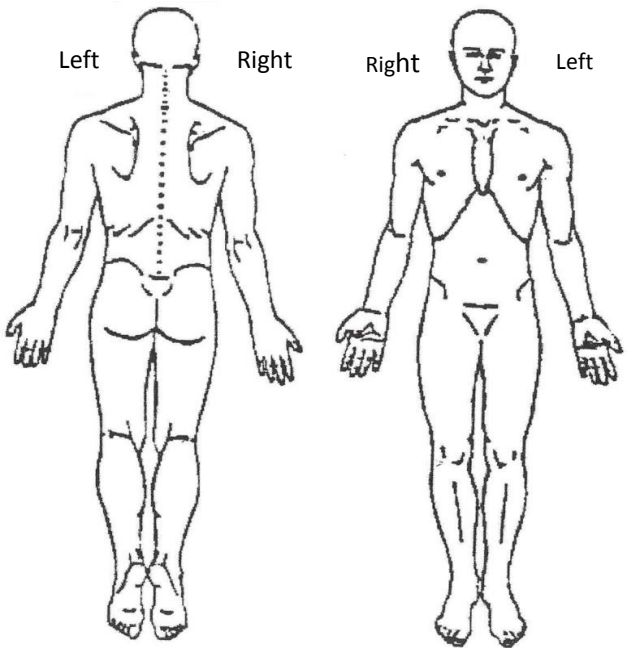
PSYCHOLOGICAL
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Other:

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time.

Use the symbols below to describe your pain. **DO NOT** indicate areas of pain which are not related to your present injury or condition.

KEY:	XXX = Pain	//// = Numbness/Tingling	OOO = Stabbing



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PAST MEDICAL HISTORY

Do you have a **HISTORY OF** any of the following? Please check all that apply.

BONES/JOINTS
- ☐ Osteoporosis/Osteopenia
- ☐ Arthritis

HEART
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Atrial Fibrillation

CIRCULATION
- ☐ Blood Clots
- ☐ High Blood Pressure
- ☐ Stroke/TIA
- ☐ High Cholesterol

KIDNEY
- ☐ Infection
- ☐ Stones
- ☐ Dialysis

CURRENT INFECTION
- ☐ Pneumonia
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ MRSA

LUNG
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema

GLANDS
- ☐ Diabetes
- ☐ Thyroid

NEUROLOGICAL
- ☐ Neuropathy
- ☐ Seizures/Epilepsy
- ☐ Parkinson's Disease

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

DIGESTIVE
- ☐ Heartburn
- ☐ Reflux

OTHER
- ☐ Liver Disease
- ☐ Skin problems
- ☐ Cancer - If so, where?

Past surgeries and the year they occurred (or attach list):

- ☐ None
- ☐ Hernia
- ☐ Tonsils/Adenoids
- ☐ Gallbladder
- ☐ Cardiac
- ☐ Oral Surgery
- ☐ C-Section/Hysterectomy
- ☐ Orthopedic (please specify):

Allergies: ☐ None ☐ LATEX ☐ Seasonal ☐ Food ☐ Medications

If yes, please list: _____

Do you have metal implants? Yes/ If yes, where? _____ If yes, when? _____

Patient Signature: _____ Date: _____