DELTA
PHYSICAL THERAPY

Name (Last, First): _____

Date of birth: _____

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

Phone Number *(Please circle preferred)* (h)_____(c)_____
May we leave voicemails at this number? *YES/NO* **Texts?** *YES/NO*

Email address _____

How did you find out about Delta? (physician, friend, internet, trainer, etc.)
_____

Emergency contact: _____ **Relationship:**_____
Phone number:_____

For Medicare Patients Only:
Are you currently receiving home care services? YES/NO
If yes, expected date of completion: _____

Motor Vehicle Accident Injuries Only:
*If you are receiving care for injuries from a motor vehicle accident, in what state did the accident occur?*_____.
Are you currently seeking litigation? YES/NO
If yes, please list your attorney's name and contact information:

Newsletter ***(Please initial to indicate you would like to receive information from Delta PT)***
_____I would like to receive Professional's Newsletter, which contains information about the company and its services.

Date created: 5/3/2018
Revision History: 8/10/19 KLG

Medical History

Please circle any previous medical history below:

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other		

Have you had PT, OT or chiropractic treatment this year? YES/NO

If yes, please indicate the type and duration of treatment? _____

Have you previously had any other treatment for this condition? YES/NO

If yes, for how long?_____

Have you ever had surgery? YES/NO

If yes, please list all surgeries:_____

_____

Are you currently taking any medications or supplements? YES/NO

If yes, please list all medications *(You may right on the back if needed)*: _____

_____

_____

_____

Please list below any known allergies:

_____

_____

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What brings you in to Delta Physical Therapy today?

_____

_____

Please list your goals for physical therapy treatment?

_____

_____

Are you having any pain? YES/NO

If yes, please provide the following:

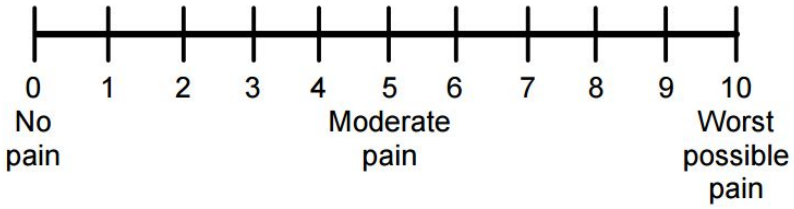
Location: _____

How Long? (days, weeks, months, years): _____

What makes it BETTER?: _____

What makes it WORSE?: _____

0–10 Numeric Pain Rating Scale



Does the pain interfere with your daily life? YES/NO

If yes, please provide a brief description:

_____

_____

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