Patient Information

Last Name_____ First Name and Initial_____

Home Phone_____ Work Phone_____ Cellular_____
Preferred contact number regarding appointments_____
Address_____City_____Zip Code_____
Date of Birth_____ Social Security #_____ Employer_____
Emergency contact_____ Phone_____
Please list your primary insurance company_____
Please list your secondary insurance if applicable _____
Have you received physical therapy this calendar year? Yes___ No___
Have you received physical therapy in the past 60 days? Yes___ No___
Have you previously received physical therapy for this condition Yes___ No___
Have you received speech therapy this calendar year? Yes___ No___
Were you hospitalized recently? Yes_____ No_____ Dates of hospitalization from_____to_____
Reason for your hospitalization_____
Have you had any falls in the past year? Yes_____ No_____
What is your major complaint today? _____
_____
What is the date of injury/onset? _____
Please indicate if you have had any of the following tests that relate to your current condition
___X-rays ___MRI ___EMG ___ Bone Scan Other_____
Which physician referred you to physical therapy?_____
Who is your primary physician? _____
The referring physician will automatically get a copy of our report.
Would you like your primary physician to get a copy of our report? Yes___ No___

Do you have now or have you had any of the following medical conditions?

Heart problems	Yes__ No__	Breathing problems	Yes__ No__	Diabetes	Yes__ No__
Pacemaker	Yes__ No__	High blood pressure	Yes__ No__	Flat Feet	Yes__ No__
Fractures/broken bones	Yes__ No__	Osteoporosis	Yes__ No__	Cancer	Yes__ No__
Hip/Joint Replacements	Yes__ No__	Hernia	Yes__ No__	Hepatitis	Yes__ No__
CVA/Stroke	Yes__No__	Rheumatoid Arthritis	Yes__No__	Multiple Sclerosis	Yes__ No__

Prior to the onset of this condition were you involved in any type of exercise program?
If so, what type of exercise and how often? _____
_____
Please list any surgeries or recent hospitalizations you have had in the last three years.
_____
_____
_____