PATIENT INFORMATION

YOU

First Name: MI: Last Name:
Address:
City: State: Zip:
Phone: Cell: Email:

PARENT/GUARDIAN (if applicable)

First Name: MI: Last Name:
Address:
City: State: Zip:
Phone: Cell: Email:

EMERGENCY CONTACT

Name: Phone:
Relationship to Patient:

INSURANCE

Primary Insurance Provider (if applicable)
Name of Insurance: Group #: Policy ID#:
Name of Insured: Date of Birth:

Secondary Insurance Provider (if applicable)
Name of Insurance: Group #: Policy ID#:
Name of Insured: Date of Birth:

I confirm that the above contact and insurance information is correct.

Signature of Patient Date

Signature of Parent/Guardian (if applicable) Date

PATIENT MEDICAL HISTORY

GENERAL

Name: Date of Birth: Sex: M F

General Health Level: Poor Moderate Good Current Activity Level: Low Moderate High

THERAPY

Were You Referred Here by Another Physician/Professional: Yes No

If Yes, Name of Physician/Professional: Phone:

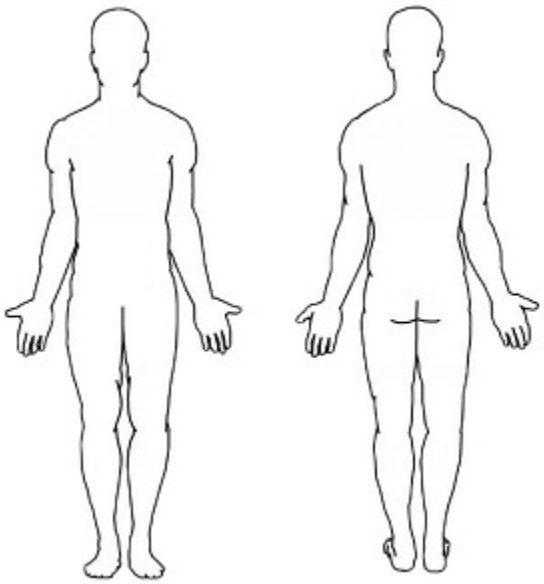
Reason for Therapy:

Cause of Injury/Condition: Date:

Specific Concerns/Limitations:

Current Pain Level (on a scale of 0 – 10, 0 = no pain, 10 = worst pain ever):

Please Indicate the Location of Current Pain by Marking Each Location with an 'X':



Describe Any Current Treatment:

Have You Had This Problem Before: Yes No

If Yes, Please Describe:

Are You Currently Receiving/Have You Ever Received Physical Therapy: Yes No

If Yes, Please Describe:

MEDICAL

Do You Currently Have/Have You Ever Had Any Broken Bones: Yes No

If Yes, Please Describe:

Do You Currently Have/Have You Ever Had Any Muscle, Tendon, or Ligament Damage: Yes No

If Yes, Please Describe:

Do You Currently Have/Have You Ever Had Any Screws, Plates, Rods, Fusions, etc.: Yes No

If Yes, Please Describe:

Please List Any Current Medications:

Please List Any Current Vitamins, Supplements, etc.:

Please List Any Allergies:

Do You Currently Have/Have You Ever Had Any of the Following:

Alcohol Use		Infectious Disease	
Anemia		Loss of Balance/Falls	
Arthritis		Loss of Coordination	
Asthma		Multiple Sclerosis	
Brain Injury		Muscular Dystrophy	
Cancer		Numbness/Tingling	
Currently Pregnant		Osteoporosis	
Depression		Pacemaker	
Diabetes		Parkinson's Disease	
Dizziness/Fainting		Seizures/Epilepsy	
Drug Use		Stroke	
Headaches		Tobacco Use	
Heart Attack/Heart Disease		Weakness	
Hyper/Hypotension		Weight Gain/Loss	

For Any Yes Answers, Please Describe:

Please List Any Other Medical Problems:

Please List Any Surgeries and Approximate Dates (month/year):

I confirm that the above medical information is correct.

Signature of Patient Date

Signature of Parent/Guardian (if applicable) Date