Patient History

Name:______________________________________ DOB:_____/_____/_____
SSN:_______________________________________ Email:______________________________
Address:____________________________________ Phone:______________________________
City, State, Zip______________________________ Employer:____________________________
Emergency Contact:__________________________ Marital Status:_________________________
Emergency Contact Phone:_____________________ Primary Care Physician:____________________

Date of next MD follow up:_____/_____/_____ Is this injury...? Work Related Auto Accident
Date of Injury/ Onset:_____/_____/_____
Chief Complaint:____
List any/all medications you are currently taking. (If you have a list we can take a photocopy):
____

Are you allergic to any medications, adhesives or latex?____________________________________
Have you fallen in the past year?_______ If so, how many times?______ If so did you sustain an injury?____________
Have you had any physical therapy during the current calendar year?_________ Have you had any physical therapy for the same condition for which you are here today?_________ If yes, please indicate where and when:_______________
____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, etc.) & where taken:_______________________
____

Please list all surgeries you have had; please give procedures and dates, if possible:____________________
____

Are you aware of your Diagnosis? Yes___ No___ Are you aware of your Prognosis? Yes___ No___
List your goals you hope to achieve through physical therapy:
1:____
2:____

Have you ever had: (Please check if applies)

- ☐ Asthma, Bronchitis or Emphysema
- ☐ Shortness of Breath/ Chest Pain
- ☐ Coronary Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Heart Attack/ Surgery
- ☐ Stroke/ TIA
- ☐ Blood Clot/ Emboli
- ☐ Epilepsy/ Seizures
- ☐ Thyroid Trouble/ Goiter
- ☐ Anemia
- ☐ Infectious Disease
- ☐ Possibility you are pregnant
- ☐ Diabetes
- ☐ Cancer or Chemo/ Radiation
- ☐ Arthritis/ Swollen Joints
- ☐ Osteoporosis
- ☐ Varicose Veins
- ☐ Gout
- ☐ Sleeping Difficulties
- ☐ Emotional/ Psychological Problems
- ☐ Bowel or Bladder Problems
- ☐ Severe/ Frequent Headaches
- ☐ Vision/ Hearing Difficulties
- ☐ Dizziness or Faintness

Smoke: Daily:___________ For how many years?
Alcohol Consumption: Daily:______________________
Exercise: Weekly:_________________________
Other Medical Conditions:______________________________________

Signature:____ Date:_____/_____/_____
Revised 07/18/2019