Patient Identifier

PATIENT INFORMATION HISTORY
All fields must be completed

NAME: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

NEXT DOCTOR'S APPOINTMENT _____

WHAT TYPE OF WORK DO YOU DO? _____

What is your physical problem?/ Why did your doctor send you for therapy?

_____

If you have had recent surgery, please give type of surgery and date:

_____

When and how did this problem start?

_____

How does this problem interfere with your normal daily activities?

_____

_____

What previous treatment did you have for current condition?

_____

What medications are you currently taking? (We can make a copy if applicable)

_____

Are you currently receiving home health therapy or home health nursing? _____

In the past 60 days were you hospitalized and/or receiving therapy services? _____

PLEASE LIST ANY PAST SURGERIES:

_____

_____

Do you have any metal implants: (such as IUD, wires, pins, screws, artificial joints)

_____

DRUG ALLERGIES: (such as xylocaine, betadine/iodine, chlorine, cortisone, etc.)

_____

Do you have any other information or health problems your therapist should know?

_____

Please check all that apply to you:

☐ blood pressure issues	☐ heart problems	☐ pacemaker	☐ cancer	☐ shortness of breath
☐ rheumatoid arthritis	☐ osteoporosis	☐defibrillator	☐ pregnancy	☐ COPD
☐ osteoarthritis	☐ diabetes	☐ seizures	☐ vertigo	☐ asthma
☐ incontinence	☐ bowel issues	☐ constipation	☐ dizziness	

If you have checked any of the above, please explain: _____

_____

Patient Signature: _____ Date: _____

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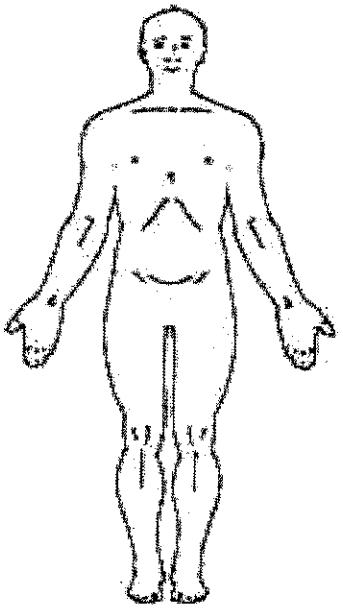
What do you hope therapy will do for your problem? _____

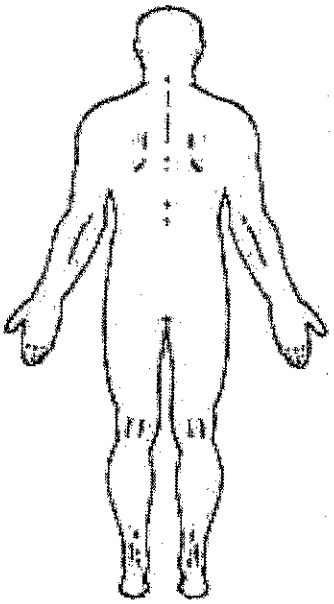
Do you have any learning barriers that we need to be aware of? _____

How do you learn best: VISUAL / DEMONSTRATION / OTHER _____

Is there anything else you wish to add? _____



Anterior



Posterior

Lateral

Please shade in area(s) where you are having pain.

Pain Intensity: 0 – 10 0 = no pain 10 = severe pain

_____

_____

_____

_____

_____

May we contact you after therapy for follow-up? ☐ **YES** ☐ **NO**

May we leave a message? ☐ **YES** ☐ **NO**

TELEPHONE#: (home) _____ **TELEPHONE #(work/cell):** _____

IS THERE ANYONE ELSE WE SHOULD TALK TO REGARDING YOUR CARE? _____

Patient Signature: _____ Date: _____

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