PATIENT INFORMATION

PLEASE PRINT DATE:_____

GENERAL INFORMATION

Name: _____

Address: _____
Street City State Zip Code

Name of Guarantor/Responsible Party (if applicable): _____

Address (if different from above):_____
Street City State Zip Code

Email Address: _____

Best Contact Phone :_____Work/Cell:_____

Social Security Number: _____ Referring Physician: _____

Sex: Male _____ Female _____ Birth Date _____

Marital Status: _____Single _____Married _____Widowed _____Divorced ____Separated

Emergency Contact: _____ Contact Phone Number _____

Employer:_____ Occupation:_____

SOCIAL HISTORY

Do you use or smoke tobacco products, now or in the past? YES___ NO___
How much and how often? _____

Do you drink alcohol? YES___ NO___
How much for day, week, or month?_____

YOUR MEDICAL HISTORY

_____ Heart Attack	_____ Asthma	_____ Lung Disease
_____ Stroke	_____ Anemia	_____ Kidney Disease
_____ High Blood Pressure	_____ Rheumatoid Arthritis	_____ Liver Disease
_____ Low Blood Pressure	_____ Thyroid	_____ Shortness of Breath
_____ Diabetes	_____ Pacemaker	_____ Gout
_____ Epilepsy/Seizures	_____ Spinal Stimulator	_____ Fainting
_____ High Cholesterol	_____ Fibromyalgia	_____ Dizziness
_____ Headaches	_____ Peripheral Vascular	_____ TB

_____ Cardiac Issues :_____
_____ Psychological Disorder: _____
_____ Cancer: _____
_____Other:_____

MEDICAL HISTORY

Is your injury the result of a car accident? _____No _____Yes
If Applicable please provide the following: Date of injury/ Name of Insurance Company/ Claim Number/ and/or Attorney's Name and phone number. _____

_____

Please list any allergies/ drug allergies:_____

_____

Please list all medications you are currently taking:_____

_____

Have you had any imaging studies done related to your current issue (xray, CT scan, MRI)?_____

Have you ever had surgery? _____No _____Yes If yes, please explain (include dates):

_____

_____

Have you ever had surgery recommended but not performed? _____No _____Yes
If yes, please explain _____

_____

Have you ever had a back injury? _____No _____Yes
If yes, please explain_____

What is your goal for your physical therapy?_____

_____

Patient Signature Date