

Name: _____
Last

First MI Jr/Sr

Street Address: _____

City State Zip

Cell Phone #: _____

Email Address: _____

Other Address: _____

City State Zip

Date of Birth: ____/____/____
Month Day Year

EMERGENCY CONTACT

Name: _____

Phone: _____

TYPE OF INSURANCE

1°: _____

2°: _____ or **Self-Pay**

EMPLOYMENT STATUS

- a) Full-time d) Self-Employed
b) Part-time e) Student
c) Not Employed f) Retired

g) Occupation _____

LIVING ARRANGEMENT?

- a) Alone
b) Spouse
c) Other: _____

LIVING ENVIRONMENT

Does your home have: or **Do you use:**

- a) Stairs, no railing a) Cane
b) Stairs, railing b) Walker
c) Ramps c) Manual wheelchair
d) Elevator d) Motorized wheelchair
e) Uneven terrain e) Glasses, hearing aids
f) Assistive devices (bathroom): _____

FALL HISTORY – Have you fallen in the past year?

- a) Yes a) No

When and were you injured: _____

MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

- a) Arthritis g) Parkinson disease
b) Broken bones/fractures h) Multiple Sclerosis
c) Osteoporosis i) Stroke
d) Heart problems j) Cancer
e) High blood pressure k) Diabetes
f) Blood Clots l) Emphysema

Please list any surgeries you've had:

Month Day Year
_____/_____/_____
_____/_____/_____

HOSPITALIZATIONS

Have you been HOSPITALIZED recently?

- a) Yes b) No

When: _____

HOME HEALTH CARE

a) Do you currently have health care even if only nursing?

(1) Yes (2) No

b) If No, have you had it recently? (1) Yes

Discharge Date _____

MEDICATIONS (Provide list if needed)

Ex. Tylenol Daily 200mg

1. _____
2. _____
3. _____

WHO REFERRED YOU TO PHYSICAL THERAPY?

YOUR CHIEF COMPLAINT(S)

Any PAST treatments or TESTS & results?

What are your GOALS for therapy? _____