TEAM™ PHYSICAL THERAPY P.C.

Together Empowering Able Movement

PATIENT HEALTH INFORMATION

Please fill in all lines so we can better assist you

Today's Date: _____

Patient Full Legal Name: _____ Nick Name: _____

Birth Date: _____ Age Today:_____ Height: _____Weight: _____ Marital Status: S M D W

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____ Employer City/State: _____

Referring Doctor: _____ **Family Doctor:** _____

Date of last Dr. visit: _____ Date of last Dr. visit: _____

Are you currently receiving: Home Health / Hospice / Physical Therapy / Occupational Therapy / Speech Therapy

PATIENT HEALTH HISTORY: PLEASE BE AS SPECIFIC AS POSSIBLE

	YES	NO	Explain:			YES	NO	Explain:
Allergies:					Seizures			
Medications/Latex					Stroke			
Lotions/perfumes					Osteoporosis			
Arthritis					Pregnancies			Current? Y/N
Asthma					Vision Problems			
Cancer					Weight Loss/Gain			
COPD/Emphysema					How much/often do you exercise:			
Diabetes								
Headaches					Past Surgeries (please list):			
Heart Condition								
High Blood Pressure								
High Cholesterol					Please attach a list of all medications you are			
Pacemaker/Defibrillator					currently taking including dose & frequency			
Muscle Pain					*OR* name your Pharmacy			
Joint Pain								
Neurologic Issues								

Area to be treated: _____ **Date of onset of pain:** _____

Reason for Treatment (*what caused the pain/problem? Be specific*):

Is your visit today due to accident? Y/N _____ Date of accident _____ Did you see a doctor: Y/N _____

Were the injuries repaired with any surgical procedures? Y/N _____ Date of Surgery: _____

Have you fallen in the last 12 months? Y/N _____ With injury? Y/N _____