

PATIENT HISTORY

(PLEASE PRINT CLEARLY & COMPLETE ALL INFORMATION)

Date: _____ E-Mail Address: _____

Patient: _____ SS# _____

LAST NAME FIRST NAME MI

D.O.B.: _____ Age: _____ Sex: M () F () Home phone: _____

Address: _____

STREET CITY/STATE ZIP

Presently working: Y () N (), Occupation: _____ Business phone: _____

Emergency contact: _____ Relation to patient: _____ Phone: _____

What is your primary complaint?: _____ Date of onset: _____

Currently receiving treatment for this condition elsewhere?: N () Y () _____

Have you received Physical Therapy for this condition or any other condition any time this year? N () Y ()

Name of Referring Physician: _____

Name & Phone Number of Primary Care Physician: _____

Diagnostic tests performed: _____
(I.E., x-ray, cat scan, emg, arthogram, myelogram, MRI, etc.)

Known Medical Conditions (past/present): _____
(I.E.: cardiac, diabetes, pacemaker, pregnancy, tumor/malignancy, allergies)

Previous Hospitalization/Surgery: _____

Current Medications: _____
What type, and for how long?

Attorney representing you in this case?: N () Y () Name: _____

How did you hear about our office?: Primary Care (), Specialist (), Previous treatment (),
Other ().. _____

Whom may we thank for referring you?: _____