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: _____

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: _____

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

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

Have you fallen in the last 12 months? Yes / No _____ With injury? Yes / No _____

Is your visit today due to a surgery? Yes / No _____ Date of Surgery: _____

Is your visit today due to accident? Yes / No _____ Date of accident _____

Work related injury: Yes / No _____ Motor vehicle accident: Yes / No ___ Liability Claim: Yes / No ___

If you answered Yes to the above accident questions please complete Work Comp/Liability Authorization.

PATIENT HEALTH HISTORY: PLEASE BE AS SPECIFIC AS POSSIBLE

	YES	NO	Explain:		YES	NO	Explain:
Pacemaker/Defibrillator				Seizures			
Are you currently Pregnant?				High Blood Pressure			
Depression				Osteoporosis			
Bipolar Disorder				Cancer			
Diabetes				Stroke			
Dementia				Neurologic Issues			
COPD/Emphysema				How much/often do you exercise:			
Asthma				Past Surgeries (please list):			
Headaches							
Arthritis							
High Cholesterol							
Allergies: Medications/Latex Lotions/perfumes				Attach all current medications OR name your Pharmacy:			

For office use:

Pain rating:	Dx:	Functional Test/Score: