PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ M _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

D.O.B.: _____ **Gender:** male / female **Pronoun (optional):** he / she / they / ze / ey

Phone: _____ **Email:** _____

EMERGENCY CONTACT

Last Name: _____ **First Name:** _____

Relationship: _____ **Phone:** _____

EMPLOYER INFORMATION

Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

PRIMARY CONCERN

Description: _____

Date of Injury: _____ **Motor Vehicle Accident:** Y / N **State Accident Occurred:** _____

Referred By: _____ **Last MD Visit:** _____

Notes: _____

_____

PRIMARY INSURANCE

Insurance: _____

ID: _____ **Group #:** _____ **Copay:** _____

Deductible: _____ **Coinsurance** _____ **Max Benefit** _____

SECONDARY INSURANCE

Insurance: _____

ID: _____ **Group #:** _____ **Copay:** _____

Deductible: _____ **Coinsurance** _____ **Max Benefit** _____

Montefiore

Patient Name: _____ MRN: _____

Patient D.O.B.: _____ Date: _____

MEDICATION INFORMATION

Please complete required information regarding ALL medications, vitamins, herbals or dietary supplements you are currently taking.

☐ I am currently **NOT** taking any Medication, Prescription, Over the Counter, Vitamins, Herbals, or Dietary Supplements

MEDICATION (prescription, over-the-counter, vitamins, herbals, dietary supplements)	**DOSAGE**	**FREQUENCY** (times per day)	**ROUTE** (oral, injection, transdermal, inhale)	**REASON FOR MEDICATION**

Provider (print name): _____ Date: _____

Signature / Credentials: _____ Time: _____ AM / PM

Montefiore

Patient Name: _____ MRN: _____

Patient D.O.B.: _____

MEDICAL HISTORY

	YES	NO	ONSET DATE
COVID-19			
Anemia			
Chest pain / heart attack / coronary artery disease			
High Blood Pressure			
Arthritis			
Pulmonary Condition			
Cancer			
Diabetes			
Abnormal Bleeding / Clotting			
Vision Deficits			
Depression / Anxiety			
Hearing Problems			
Kidney Disease			
Osteoporosis			
Falls			
Fractures			
Seizures			
Incontinence			
Thyroid Disorder			
Strokes / TIA			
Active Infection			
Other Neurologic Disorder			
Loss of Consciousness			
MRSA / VRE / C-Diff			
Headaches			
Skin Disorder			
Other			

Please list and date any significant medical / surgical history

Montefiore

Patient Name: _____ MRN: _____

Patient D.O.B.: _____

PRIMARY MEDICAL CONCERN REQUIRING REHABILITATION

_____

ALLERGIES

☐ Yes ☐ No Allergic Reaction _____

SPECIAL TEST

X-Ray	CAT Scan	MRI	Bone Scan	Other
Date & Result				

Have you ever had therapy for this problem? ☐ Yes ☐ No

Are you under anyone else's care for this problem now? ☐ Yes ☐ No

Have you had Physical Therapy / Occupational Therapy before? ☐ Yes ☐ No

If yes, please explain _____

SOCIAL HISTORY

Cultural Needs

Do you require an interpreter? (Bilingual patients may need an interpreter) ☐ Yes ☐ No

What is the primary language spoken at home? _____

Are there any cultural / religious practices that you would like us to be aware of before treatment? ☐ Yes ☐ No

If yes, please explain _____

Home Status

Current living arrangement Live Alone ☐ Live w. Partner ☐

Live w. Family/Friend ☐ Other: _____

Do you live with children 18 years or younger? ☐ Yes ☐ No

Do you have stairs going into your home / building? (If yes, how many steps?) _____ ☐ Yes ☐ No

Have you had a fall in the last 12 months? ☐ Yes ☐ No

Do you have a fear of falling? ☐ Yes ☐ No

Smoking History

☐ Current Smoker # Packs per day _____

☐ Former Smoker Quit Date ____/____

☐ Never Smoked

Use of Alcohol

☐ Social ☐ Weekly ☐ 1 – 2 per day ☐ 2+ per day

Montefiore

Patient Name: _____ MRN: _____

Patient D.O.B.: _____

Occupation

Are you currently working? (If yes, list job title) _____ ☐ Yes ☐ No

PAIN

Do you have persistent or frequent pain? ☐ Yes ☐ No

Location on body _____

Does pain affect your daily activities? ☐ Yes ☐ No

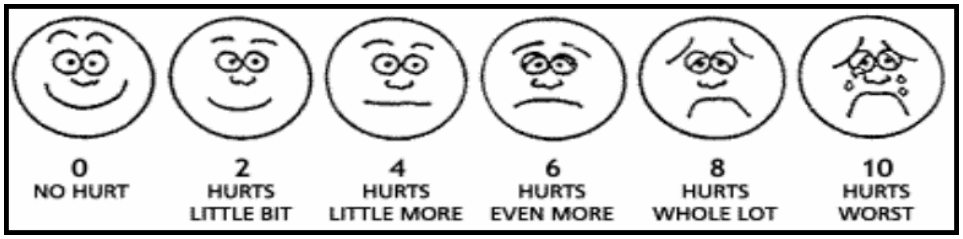
Does pain awake you at night? ☐ Yes ☐ No

Circle One

0	1	2	3	4	5	6	7	8	9	10

Mild **Moderate** **Severe**

NO PAIN



WORST PAIN

Do you have durable medical equipment? (i.e. walker, wheelchair, etc.) _____

What exercises of sports do you participate in? _____

List your three major **FUNCTIONAL** difficulties / problems
(e.g. self-care, household chores, changing positions, shopping, transportation, walking, communicates wants & needs)

1. _____
2. _____
3. _____

List your three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____

Provider (print name): _____ Date: _____

Signature / Credentials: _____ Time: _____ AM / PM