

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: _____

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

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

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

Occupation

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

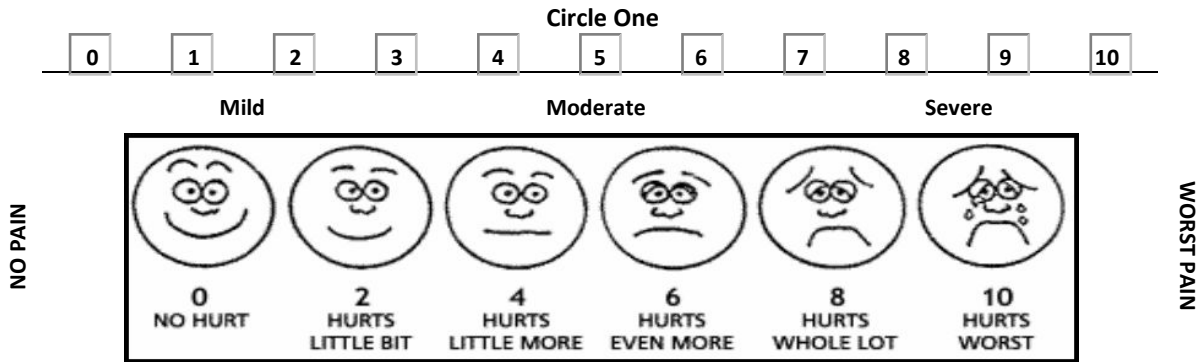
PAIN

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



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

What exercises or 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