PATIENT INFORMATION FORM

Name: _____ **Date of Birth:** _____ M/R#_____
Address: _____
City, State, Zip: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

What is the problem that brings you to physical therapy? _____
_____
What are your goals for physical therapy? _____
_____
Do you take prescription medication? ☐ YES ☐ NO
If yes, please list: _____ _____ _____
_____ _____ _____

Do you take non-prescription medications? ☐ YES ☐ NO

Advil/Aleve Antacids Ibuprofen/Naproxen Other _____
Antihistamines Aspirin Decongestants
Herbal Supplements Tylenol Sleeping Aids
Do you have any adverse reactions to medications? ☐ YES ☐ NO
If Yes, please list and describe reaction _____

Please check ☑ if you have ever had:

	Arthritis		Developmental/Growth problems		Cancer
	Fractures		Osteoporosis		Diabetes/High Blood Sugar
	Stroke		Blood Disorders		Hypoglycemia
	Ulcers		Circulation/Vascular problems		Seizures
	Kidney problems		Heart problems		Head Injury
	High Blood Pressure		Multiple Sclerosis		Thyroid problems
	Depression		Anxiety		Epilepsy
	Parkinson disease		Muscular Dystrophy		Repeated infections
	Skin disease		Stomach problems		Tuberculosis
	Hepatitis A, B, or C		HIV/AIDS		**Pacemaker/AICD**
	Other				

Have you ever had surgery? ☐ YES ☐ NO
If Yes, Please describe and include dates. _____
_____

Are you pregnant or think you might be? ☐ YES ☐ NO

Do you have any known drug allergies? ☐ YES ☐ NO If yes, which ones: _____

Please rate your overall health: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Date of last Physical: _____

Quality Rehab. Care, LLC
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Do you currently smoke? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO
Do exercise beyond normal daily activities and chores? ☐ YES ☐ NO
Please describe _____

Are you experiencing the need for the following Social services?

Financial:	Please check ☑ Yes	No
Do you have enough money to buy the food you need?		
Do you have enough money to buy the medical care/medications you need?		

In Home Care:	Please check ☑ Yes	No
Do you need someone to stay with you at home?		

Socialization:	Please check ☑ Yes	No
Do any physical problems stand in the way of you doing things?		
Do you participate in activities outside the home?		

Mental Health:
How would you describe your satisfaction with life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Compare this year with last year's satisfaction? ☐ Better ☐ Same ☐ Worse

Do you currently receive?	Please check ☑ Yes	No
Home health Services		
Community Services (Meals on wheels)		
Mental Health Services		
Is the mental health service meeting your needs		

Please use this space for any additional information you would like us to know:

Print Patient Name: _____

Patient Signature: _____

Date: _____