



PATIENT INFORMATION FORM

Patient Name: _____ **DOB:** _____

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

Please check

- 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

Physician Name: _____

Date of last Physical: _____



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Do you currently smoke? YES NO
 Do you drink alcohol? YES NO
 Do you exercise beyond normal daily activities and chores? YES NO

Please describe _____

Height: ____ ' ____ " Weight: ____ lbs.

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?	Yes	No
Do you have enough money to buy the medical care/medications you need?	Yes	No

In Home Care: Please check Yes No

Do you need someone to stay with you at home?	Yes	No
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Socialization: Please check Yes No

Do any physical problems stand in the way of you doing things?	Yes	No
Do you participate in activities outside the home?	Yes	No

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	Yes	No
Community Services (Meals on wheels)	Yes	No
Mental Health Services	Yes	No
Is the mental health service meeting your needs	Yes	No

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

Print Patient Name: _____

Patient Signature: _____

Today's Date: _____