

Name: _____ DOB: _____ Age: _____

E-mail _____

Your Employer: _____ Occupation: _____

Work Number: _____ Family Physician: _____

Emergency Contact Name: _____ Phone: _____

Relationship: _____

How did you hear about us?: _____

What are your goals? What do you want to accomplish with Physical Therapy?: _____

Have you ever had previous treatment for this problem?: _____ If yes, please explain: _____

Basic Health History: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back or neck problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint pain or problems |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Impaired hearing |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Impaired vision |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Recent antibiotic use |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Frequent urination (more than 8x/day) |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Difficulty holding bowel or bladder |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Illegal drug use |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Neurological disorders (polio, M.S., A.L.S., etc.) | _____ |

For Women Only:

- Currently pregnant (or trying) Pelvic/rectal pain Painful intercourse

Please list all medications & supplements you are currently taking: _____

Please list any surgeries you have had: _____

Patient signature: _____ Date: _____

Re-occurring patients only:

Please list any changes in your health history:

Initial: _____ Date: _____