Finest PHYSICAL THERAPY

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Today's Date: _____

PATIENT INFORMATION

Last Name: _____ First: _____ Middle I:____ Marital Status: (circle one): S/ M/ D/ W
Street Address:_____City:_____State:_____Zip code:_____
Home Phone:_____ Cell:_____DOB: _____Age:_____ Sex: F/ M SS#_____-_____-_____
Email address:_____ Occupation:_____ Employer:_____
Employer Address: _____City:_____State:_____Zip code:_____
Emergency contact:_____ Phone number:_____
Drivers License #:_____

INSURANCE INFORMATION

Primary Insurance: _____Policy/Subscriber:_____ Policy ID#_____
Address:_____City:_____State:_____Zip code:_____Group #:_____
Secondary Insurance: _____Policy/Subscriber:_____ Policy ID#_____
Address:_____City:_____State:_____Zip code:_____Group #:_____

MEDICAL QUESTIONAIRE

Primary Care Physician:_____Phone number:_____

Circle any Medical Conditions listed that you are currently being treated for : ***Arthritis, Cancer, Diabetes, Hypothyroidism, Hyperthyroidism, Asthma, High/Low Blood Pressure, Lung Issues, Chest Pain, Blurred Vision, Balance Problems, Deafness, Tinnitus, Fainting, Stroke, Anemia, Epilepsy, Angina, Blood Clots, Multiple Sclerosis, Circulation Problems, High Cholesterol, Eye Infections, Joint/Bone Infection, Musculoskeletal Problems. Tuberculosis, Depression, Heart Problems, Liver Problems, Pneumonia, Urinary Infection, Pacemaker***

List any Medical Conditions not stated above that pertain to you:_____

Circle Any Pertinent Family History: **Cancer, Diabetes, Stroke , HTN, Cardiac Problems, Lung Conditions**
Do you have any allergies? Y/ N List: _____
Are you pregnant? Y/ N N/A
Have you ever had surgery? Y/ N If yes describe:_____
List medications currently taking:_____
Do you smoke cigarettes? Y/ N Do you drink alcohol? N/ Y _____# of drinks/day, ___Occasional/Social
Did someone refer you to this office? Y/ N If yes please name that person or group:_____
Is your illness/injury related to an automobile accident? Y/ N Date:_____
Is your illness/injury work related? Y/ N Date:_____
Briefly describe the reason that brought you to this office:_____
What are your current chief complaints: _____
When did your present symptoms start? _____
Have you ever had a similar episode of this problem before? _____
What is your pain level at its worst in the past week(scale 0-10; 0=nothing and 10=worst): _____
Have you ever had Physical Therapy before? Y/ N If so for what conditions:_____

Patient or Guardian Signature:_____Date:_____