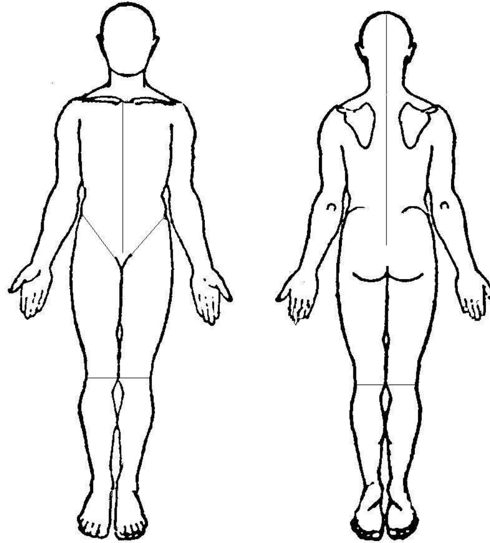
United Physical Therapy
Patient Information

Name:______________________________ Age:_____ Birthday:___________________
Phone:
Home: ___________________ Work: ________________ Cell: ________________

- Please color the regions of your body in which you are experiencing pain today.



- Describe your pain or discomfort: "0" is no pain or discomfort. "10" is the worst pain of your life.

  Now: ____ At Worst: _____ At Best: _____

- Onset:
- If more than a year ago, what brought you in today?
- Nature of injury/condition:
- Treating physicians (including family, orthopedic, neurologist, neurosurgeon) and chiropractors:
- Circle all tests that you have had for this condition/injury: X-rays MRI CAT scan EMG
- Location of tests:
- Have you had treatments for your condition? Where? Please describe.
- Have you experienced any falls in the past year? YES NO
- If yes, how many falls have you had? ___________
- Have you been injured as a result of a fall? YES NO Please describe:______________________

- Are you taking any medications?   Please list their intended purpose.

- Ladies, Are you pregnant? ________   If so, how many months?_____________

- Have you been hospitalized in the last 3 years? ______   Where?_______________

- Reason for hospitalization:

- Medical history: Please check box where appropriate. Please specify condition and year.

_____High blood pressure
_____Diabetes
_____Osteoporosis
_____Arthritis
_____Gout
_____Metal Implants (including staples, joint replacements, pins, screws, etc.)
_____Seizures
_____Spinal fractures
_____Major surgeries____

_____Heart problems: _________________________
_____Lung problems: __________________________
_____Cancer:_______________________________
_____Stroke: _______________________________
_____Thyroid problems:________________________
_____Abdominal problems:______________________
_____Other:________________________________

- What are your goals for your physical therapy?

It is our goal to satisfy your physical therapy needs and provide you with outstanding care that sets us apart. Please let us suggest the following:

1) **Please attend your scheduled physical therapy visits**.
Consistent attendance will assist in your recovery.

2) **If you are unable to attend your physical therapy visit, please call us to cancel or reschedule.**
24 Hour notice is preferred; however we understand emergencies occur. We reserve the right to discontinue your therapy if you do not cancel your scheduled PT visits. We will make every effort to work with you prior to discontinuing your therapy.

3) **Please be on time for your therapy appointments.**
If you are more than 10 minutes late, we reserve the right to reschedule your physical therapy visit.   Please call if you feel that you may be later than 10 minutes to assure that we can still fulfill your treatment plan. We will make all attempts to accommodate you.

We value your time and appreciate your business. Thank you for choosing United Physical Therapy.

Signature____ Date:____________________

United Physical Therapy, LLC
Patient Information – Part 2

Name: ___________________________Soc. Sec. #: ______________

Phone Number: (Home)_____________(Cell/Work)_____________

Address: ____

____

Patient's Birthdate: _______________Marital Status: ___________

Next of Kin: (Name) ____

(Relationship) ________________ Phone Number: ____________

Referral Source: ____
(Ex: friend, doctor, advertisement…)

We will also need you to bring in your insurance card(s) for us to photo copy.