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Patient Information

Name:_____Age:_____Birthday:_____

Home Phone:_____Work Phone :_____Cell Phone:_____

Email:_____Would you like to receive either email or text reminders? _____(specify)

Please state why you are at therapy today:_____

_____

When did this problem start? (Approximate date if exact is unknown)

_____

If this problem is more than a year old, did you have a flare-up that you have sought additional treatment?

Please describe the LOCATION(S) of your pain, discomfort or swelling <u>for which you have been referred</u> to therapy.

Please rate the pain or discomfort on a scale of 1-10, with 10 being the worst pain you have ever experienced and requiring emergency intervention.

Right now?_____/10 At best?_____10 At worst?_____/10

Is the pain, discomfort, or swelling Intermittent? _____ Constant?_____

Please tell us the reason for your condition, such as surgery, injury, fall, etc.

_____

Have you experienced any falls in the past year?_____ How many?_____ Have they resulted in injury?_____

Have you had previous physical therapy for your condition? _____

Have you had tests for your condition? Please specify dates and facility for tests.

_____

Who is your referring physician? _____ City:_____

Who is your primary care physician? _____ City:_____

Who is your podiatrist? (if applicable) _____City:_____

Have you been hospitalized in the last three years? Please list reason(s) for hospitalization.

Surgical History: (Please list any major surgeries)

PLEASE TURN OVER PAGE TO COMPLETE SECOND PAGE**********

Medical History:

- ☐ Abdominal problems
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac pacemaker
- ☐ Chemical Dependency
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Fractures
- ☐ Gallbladder problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ Incontinence
- ☐ Kidney problems
- ☐ Metal implants
- ☐ Parkinson's disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Vision problems

Any other conditions or problems:

Are you pregnant?_____

What are your goals for physical therapy?

Do you live in a single dwelling home or apartment?

Do you live alone?

Medications: Please list ALL medications, including prescription, over-the counter or herbal medications.

Name of Medication	How is it taken?	Dosage	How Often Taken	Purpose

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 agreed upon 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. Please politely give us a 24 notice. We do 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 cancel or reschedule your appointment. Please call if you feel 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, LLC.

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: _____

Address:_____

Family Physician:_____Phone:_____

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

Are you on Medicare (any type)? _____

If so, have you had any Physical Therapy, Occupational Therapy, or Speech Therapy this year? _____

If Policy Holder is other than patient:

Policy Holder Name: _____

Please turn page over***

Policy Holder Birthdate: _____

Policy Holder Social Security Number: _____

Please bring your insurance card(s) for us to photo copy. We also need a photo ID.