Barbara G. Green Physical Therapy Patient Information Form

Name_____ Date_____
Address_____ zip code_____
Home telephone_____ Cell_____ Work Telephone_____
DOB_____ Sex_____ Email _____
Referral Source_____ Primary Care Physician_____
May I send a thank you note to your referral source?_____
Emergency Contact_____ Relationship_____
Telephone_____
Hospital Preference_____
Employer_____
Address_____

Medical Information Please circle any that apply:

Allergies/Asthma
Arthritis – Osteo/Rheumatoid
Bladder problems
Bowel problems
Cancer
Carpal Tunnel
Diabetes
Drug and Alcohol Dependency
Epilepsy
Fibromyalgia
Glaucoma
Head/Neck Trauma
Heart Disease
Hepatitis
Herpes
High Blood Pressure
HIV infection
Immune Suppression
Low back pain
Lupus
Migraines, Tension headaches
Multiple Sclerosis
Osteoporosis
Phlebitis/Thrombosis
Sinusitis
Skin Disorders
Stroke
TMJ Dysfunction
Ulcers
Varicose Veins

Rest / Night pain
Recent Weight loss
Recent Infection
Fever or Chills

Are there any other health issues I need to know about? _____
_____
Do you exercise regularly? _____ If so, how? _____
Previous treatment (Physical Therapy, Chiropractor, Acupuncture)_____
_____
Surgery (Type/Date)_____
Meals per day_____ Do you consume caffeine? _____ If so, how much?_____
Do you smoke? _____ If so, how much? _____
Do you consume alcohol? _____If so, how much? _____
Tests taken – MRI_____ CT Scan _____X-ray _____ Others _____
Pain Level (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
Location of Pain _____
Medications_____

Consent for treatment: *please sign below*

_____