

Bertrand Chaffee Hospital Physical Therapy – Patient History

NAME: _____ NICKNAME/PREFERRED NAME: _____
EMAIL: _____
PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____
HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____
MEDICATIONS: _____
ARE YOU CURRENTLY TAKING AN ANTICOAGULANT (BLOOD THINNER)? IF YES, PLEASE LIST NAME: _____
ALLERGIES: _____
ANY METAL IMPLANTS (EX. JOINT REPLACEMENT)? IF YES, WHERE?: _____
DO YOU HAVE A PACEMAKER (CIRCLE ONE)? YES OR NO ARE YOU RECEIVING ANY HOME CARE SERVICES (CIRCLE ONE)? YES OR NO
HAVE YOU HAD ANY HOSPITALIZATIONS WITHIN THE LAST YEAR? _____
ANY RECENT OR RELATED SURGERIES? IF YES, PLEASE LIST: _____
DESCRIBE THE CONDITION FOR WHICH YOU'RE SEEKING PHYSICAL THERAPY SERVICES (IN YOUR OWN WORDS):

PLEASE CHECK THE FOLLOWING THAT APPLY TO YOU:

☐ HEART DISEASE	☐ EPILEPSY/SEIZURES (CIRCLE)	☐ FAINTING
☐ FRACTURE	☐ NEUROLOGICAL PROBLEMS	☐ BLOOD CLOTS
☐ HIGH BLOOD PRESSURE	☐ NUMBNESS	☐ NAUSEA/VOMITING
☐ MIGRAINES/HEADACHES	☐ DIABETES	☐ FIBROMYALGIA
☐ ASTHMA/BREATHING DISORDER	☐ WEAKNESS	☐ SKIN IRRITATION/INFECTION
☐ SHORTNESS OF BREATH	☐ TREMOR	☐ UNEXPLAINED WEIGHT LOSS
☐ VARICOSE VEINS	☐ CANCER/TUMOR	☐ STROKE
☐ NECK PAIN/SURGERY (CIRCLE)	☐ OSTEOPOROSIS/OSTEOPENIA (CIRCLE)	☐ ARTHRITIS
☐ BACK PAIN/SURGERY (CIRCLE)	☐ CIRCULATION PROBLEMS	☐ CURRENT/POSSIBLE PREGNANCY

EXPLANATION OF ABOVE/CONDITION NOT LISTED: _____

WHEN DID YOUR CURRENT CONDITION BEGIN/SURGERY OCCUR?: _____

DOES THE CONDITION FOR WHICH YOU ARE SEEKING TREATMENT LIMIT YOUR WORK/LEISURE/DAILY ACTIVITIES? IF YES, PLEASE LIST: _____

HAVE YOU HAD ANY TESTING (X-RAY, MRI, CT SCAN, ETC.) FOR THIS CONDITION? IF YES, PLEASE LIST: _____

HAVE YOU RECEIVED ANY TREATMENT (PHYSICAL THERAPY, CHIROPRACTIC, INJECTIONS, ETC.) FOR THIS CONDITION? IF YES, PLEASE LIST: _____

I AM AWARE OF MY DIAGNOSIS AND WISH TO RECEIVE TREATMENT AT BERTRAND CHAFFEE HOSPITAL PHYSICAL THERAPY. I PERMIT ITS EMPLOYEES AND ALL PERSONS CARING FOR ME TO TREAT ME IN WAYS THEY JUDGE TO BE BENEFICIAL. I UNDERSTAND THAT THIS CARE MAY INCLUDE AN INITIAL EVALUATION, TESTING, AND TREATMENT. NO GUARANTEES HAVE BEEN MADE ABOUT THE OUTCOME OF THIS CARE. BASED UPON THIS INFORMATION, I GIVE MY INFORMED CONSENT FOR TREATMENT AS PROPOSED.

DATE

PATIENT SIGNATURE