



Today's Date: _____

addressograph

Patient's Name: _____ Date of Birth: _____
 Referring Doctor: _____ Primary Doctor: _____

Occupation: _____ Full-time Part-time Retired
 Date of Injury/Problem: _____ Current Injury/Problem: _____

Do you have any allergies? Yes No, Please list: _____

Are you currently taking any prescription or non-prescription medications? Yes No
 If Yes, list medications and reason for taking: (see attached medication list)

Major surgical procedure within the last 60 days (e.g., craniotomy, laminectomy)? Yes No

List Prior Surgeries/Hospitalizations Dates:

Emergency Contact: _____ Relationship: _____ Home Phone: _____
 Work Phone: _____ Cellular Phone/Beeper: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema/Shortness of breath			Pain at Night		
Congestive Heart Failure			Severe or Frequent Headaches		
Coronary Heart Disease/Angina/Chest Pain			Vision/Hearing Difficulties		
Do you have a pacemaker/internal defibrillator?			Numbness or Tingling		
High Blood Pressure			Dizziness or Fainting		
Stroke/TIA			Weight Loss/Energy Loss		
Blood Clot/Emboli			Nausea/Vomiting		
Epilepsy/Seizures			Circulation Difficulties		
Thyroid Difficulties/Goiter			Diabetes		
Cancer (skin or otherwise; specify) _____			Any Pins/Metal Implants?		
Chemotherapy/Radiation			Joint Replacement		
Family History of Cancer			Rheumatic Fever		
Infectious Disease (specify) _____			Hepatitis		
Arthritis/Swollen Joints			Lung Disease		
Osteoporosis			Tuberculosis		
History of Falls			Liver Disease		
Sleeping Difficulties			Are You Pregnant?		
Emotional/Psychological Difficulties			Do You Smoke?		
Bowel/Bladder Problems			Lupus/Fibromyalgia		
Swallowing Difficulties			Specify Other: _____		

Do you have any religious or cultural practices that may affect your care? _____

Are you experiencing any social or emotional difficulties at home/work that you feel we should be aware of?

Are you experiencing any abuse at home? _____

List any other information that would assist us in your care: _____

Please specify your expectations/goals while in this program: _____

Patient/caregiver unable to complete form; Information reviewed and completed by therapist. _____ (Initial)
 Name of person completing form: _____ Date: _____

 Clinical Signature/Title/Initials Date Clinical Signature/Title/Initials Date

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