Marshall Physical Therapy

Patient Information Today's Date_____

Name_____ Date of INJURY _____

Address_____ Birth date _____

City_____State_____Zip _____ Home Phone _____

E-mail _____Work Phone _____

Cell Phone_____ Injury Area _____

In case of emergency, contact_____Phone_____

Family Physician_____ Referring Physician for Therapy_____

Insurance Information **Please provide insurance card for us to copy**

Policyholder_____Address _____

Employer _____Policyholder's Signature _____

Date of birth for policyholder_____ Relationship to patient _____

Group name/number_____

Insurance ID #_____Date of Injury _____

Insurance Name_____Address_____

Insurance Phone # _____

Co-pay or percentage _____Deductible _____Met for the year?_____

Worker's Compensation Information

Worker's Comp. Claim # _____ Date of Injury_____

Adjuster's name_____Adjuster's phone #_____

Billing address_____

Workplace contact person _____Phone #_____

Adjuster's Fax # _____Patient's Social Security Number _____

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Medical History

Areas of pain: _____

Date of onset/accident (**Note**: some insurance companies require this) _____

Have you had any radiographs (X-rays), CT scan or MRI reports? _____Results? _____

Please list your current medications: *(Include inhalers and birth control pills)*
_____

What health measures have you taken?
_____

Please describe your general diet, water and vitamin/supplement intake:
_____

What, if any, techniques do you use for relaxation?
_____

Please provide any additional information you believe to be important for your physical therapy:

_____

Do you have or have you previously had:

		If you answered YES, please explain here
Arthritis	Yes	no
Broken bones	Yes	no
Joint pain	Yes	no
Osteoporosis	Yes	no
Severe sprains	Yes	no
Recent weight loss/gain	Yes	no
Radiating pain in limbs	Yes	no
Numbness or tingling	Yes	no
Changes in bowel/bladder	Yes	no
Heart condition	Yes	no
High blood pressure	Yes	no
Hemophilia	Yes	no
Pneumonia/asthma or other respiratory problem	Yes	no
Diabetes	Yes	no
Cancer	Yes	no
Cysts or tumors	Yes	no
Anxiety/panic attacks	Yes	no
Loss of breath on exertion	Yes	no
Palpitations/racing heart	Yes	no
Concussions	Yes	no
Passing out/dizziness	Yes	no
Surgery	Yes	no
Pain with cough/sneeze	Yes	no
Are you pregnant?	Yes	no
Are you allergic to latex?	Yes	no
Do you have night pain?	Yes	no