Name: _____

Preferred phone number: _____ Cell phone number: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Referred to this office by: _____

Primary physician: _____ Phone: _____

When is your next appointment to see your doctor? _____

Reason for today's visit: _____

Onset of problem: Date: _____ Type: _____

If surgery required: Date: _____ Type: _____

Do you have present symptoms of:

Pain	❑ Yes ❑ No	Swallowing Problems	❑ Yes ❑ No	Night sweats	❑ Yes ❑ No
Headaches	❑ Yes ❑ No	Swelling	❑ Yes ❑ No	Night Pain	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No	Weakness	❑ Yes ❑ No	Change in bowel/bladder	
Numbness	❑ Yes ❑ No	Vision problems	❑ Yes ❑ No	incontinence	❑ Yes ❑ No
Loss of movement	❑ Yes ❑ No				

If yes, or if other, please explain: _____

How is your problem limiting your daily activities? Please explain: _____

_____

Allergies (drugs, latex, etc.): _____

Do you wear: Glasses	❑ Yes ❑ No	If female, are you pregnant?	❑ Yes ❑ No
Hearing aid	❑ Yes ❑ No	Have you ever had a hearing test?	❑ Yes ❑ No
Dentures	❑ Yes ❑ No	Have you fallen in he past 12 months?	❑ Yes ❑ No

Do you have a past history of:

High blood pressure	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Heart problems	❑ Yes ❑ No	Dizziness/Nausea	❑ Yes ❑ No
Circulation problems	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Past surgeries	❑ Yes ❑ No	Orthopedic problems	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	Pacemakers	❑ Yes ❑ No
Infectious diseases	❑ Yes ❑ No	Metal implants	❑ Yes ❑ No
Sensitive skin	❑ Yes ❑ No	Cancer	❑ Yes ❑ No

If yes, or if other, please explain and give date as necessary: _____

_____

_____

_____

_____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

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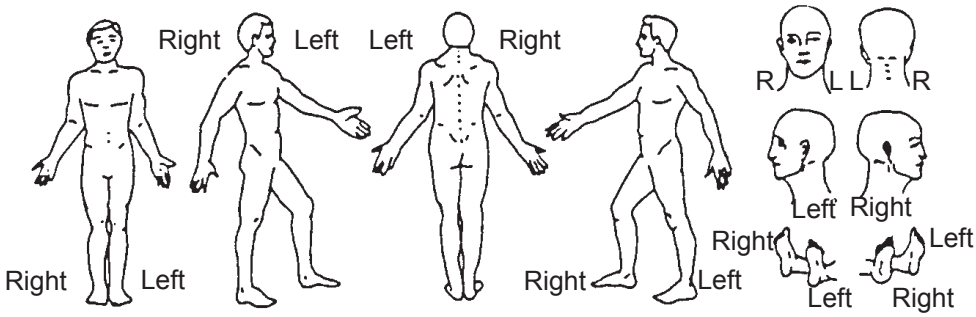
Please mark the pain site(s), if applicable, on the body figure.



Living situation: ❑ House ❑ Apt ❑ Mobile Home Stairs: ❑ Yes ❑ No
Live with anyone: ❑ Yes ❑ No Relationship: _____
Are you currently employed? ❑ Yes ❑ No If not, when did you last work? _____
Occupation: _____ Driving? ❑ Yes ❑ No
Personal goal for therapy _____

PREVIOUS CARE:

Have you ever received physical, occupational, and/or speech therapy before?

PT: Provider: _____ Date/Time frame: _____
Reason for PT: _____
OT: Provider: _____ Date/Time frame: _____
Reason for OT: _____
ST: Provider: _____ Date/Time frame: _____
Reason for ST: _____

Present medications (please include over-the-counter and herbal medication and reason for taking):

_____
_____
_____
_____
_____

By signing I declare that the information that I have provided in this form is correct and complete to the best of my knowledge.

_____	_____	_____
Patient/Representative (Print Name)	Patient/Representative Initials	Date

If you seek additional privacy during your treatment session, please inform your therapist.

PLEASE CONTACT YOUR THERAPIST IF THERE ARE ANY CHANGES TO THE ABOVE INFORMATION.

Thank you for your time.

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