PROVIDENT PHYSICAL THERAPY & REHABILITATION
Exceptional Care, Outstanding Results

Date: ____/____/____

Name: _____ **Birthdate:** _____/_____/_____
Last First Middle

Age:_____ **Sex:** ❑ F ❑ M

Address:
_____

_____

Email Address: _____@ _____

Cell Phone Number:

Provider: ❑ Verizon ❑ AT&T ❑ Sprint ❑ T-Mobile ❑ Other _____

*Please check box to receive TEXT ALERTS for appointment reminders

How would you like your appointment conformation ❑ Email ❑ Text Message

How did you hear about this clinic?

Reason for Physical Therapy? (include body part and indicate right or left)

Describe briefly your present symptoms:

Pain Scale (0-10 level):_____

Date that Injury Began? _____

Has the problem been ❑ Chronic (6weks or more) ❑ Subacute(2-6 week) ❑ Acute (less than 2 weeks)

What make symptoms better? _____

What make symptoms worse? _____

Any X Ray or MRI done ❑ Yes ❑ No **Date of Exam:** _____

Company & Location: _____ **Phone number:** _____

_____

For this injury, did you have surgery? ❑ Yes ❑ No

Hospital Name: _____

Have you ever had a similar problem? ❑ Yes ❑ No

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?:

_____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

(Please provide medication list if available)

Name of drug	Dose (include strength & number of pills per day

MEDICAL HISTORY

Do you now or have you ever had any of the following listed below?

❑ NONE
❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other Medical Conditions:

ADDITIONAL INFORMATION

Referring Doctor: _____

Address: _____

Phone Number: _____

Primary Care Doctor: _____

Address: _____

Phone Number: _____

In general, overall you would say your health is:

❑ Excellent ❑Good ❑Fair ❑Poor

Exercise Habits: _____

Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Emergency Contact: _____
Phone Number: _____
Relationship: _____

Medicare Patients only:

Have you been seen by OR are you currently being seen by a Home Health Care Agency medical care or services?
❑ Yes ❑ No If yes,When?_____

Patient Signature:_____ Date:_____