Contact Information

Name: DOB: Employment:

Marital Status: S M D W Sex: M F Social Security:

Address: City: State: Zip:

Email: Home Phone #: Cell Phone #:

Emergency Contact: Emergency #: Relationship:

Medical Information

Referring Doctor:

List other doctors involved in you cancer care, if applicable:

In the past month, have you: Been enrolled in Home Health? Y / N Had Physical Therapy? Y /N

Have you had therapy for THIS condition before, if so, where?

Known allergies:

Current Pain Level:	1	2	3	4	5	6	7	8	9	10
Worst Pain Level:	1	2	3	4	5	6	7	8	9	10
Best Pain Level:	1	2	3	4	5	6	7	8	9	10

What problem brings you to therapy?

What are your goals for therapy?

Prior surgeries/hospitalization (last 10 years):	Current list of medications and dosage:

Medical History

**Please check all that apply*

Condition	Yes	Comments	Condition	Yes	Comments
Alzheimer's / Dementia			Heart Attack		
Depression/Anxiety			Heart Disease		
Other Mental Illness			Pacemaker		
Parkinson's			Stroke		
Fracture			Fibromyalgia		
Joint Replacement			Current Infection		
Osteoarthritis			History of Cancer		
Rheumatoid Arthritis			Traumatic Brain Injury		
High Blood Pressure			Epilepsy/Seizures		
Diabetes			GI Disorders		
Obesity			Pregnancy		

Patient Signature ***Date***