FORTÉ REHABILITATION & WELLNESS CENTER — PATIENT INFORMATION RECORD

PATIENT NAME	PATIENT DOB	MARITAL STATUS S M D W	SEX M F

PATIENT ADDRESS	CITY/STATE	ZIP CODE	PATIENT SOCIAL SECURITY #

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER

PRIMARY INSURANCE	PATIENT E-MAIL ADDRESS

NAME OF PRIMARY POLICYHOLDER	**POLICYHOLDER SOCIAL SECURITY #**	**POLICYHOLDER DOB**

SECONDARY INSURANCE/POLICYHOLDER	**POLICYHOLDER SOCIAL SECURITY #**	**POLICYHOLDER DOB**

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE #

REFERRING DOCTOR	PRIMARY DOCTOR	HOW DID YOU HEAR ABOUT FORTE?

HAVE YOU HAD **HOME HEALTH** IN THE PAST MONTH?	HAVE YOU HAD **PHYSICAL THERAPY** IN THE PAST MONTH?	WHAT PROBLEM BRINGS YOU TO THERAPY?

HAVE YOU HAD THERAPY FOR THIS CONDITION BEFORE? (if yes, where)	**KNOWN ALLERGIES**

CURRENT MEDICATIONS AND DOSAGES (WE WILL BE HAPPY TO COPY YOUR MEDICATION LIST)

PRIOR SURGERIES / HOSPITALIZATION (IN LAST 10 YEARS)

MEDICAL/SURGICAL HISTORY

	YES	COMMENTS		**YES**	COMMENTS
Respiratory (COPD)			Diabetes Mellitus		
Asthma			Cancer		
High Blood Pressure			Kidney/Urinary		
Low Blood Pressure			Epilepsy/Seizures		
Dizziness			Gastrointestinal		
Heart Disease			Heart Attack		
Circulation/Vascular			Stroke		
Arthritis			Skin Problems		
Osteoporosis			Pacemaker		
Psychiatric History			Joint Replacement		
Other			Pregnancy		

CURRENT PAIN LEVEL	WORST PAIN LEVEL (PLEASE CIRCLE)	BEST PAIN LEVEL (PLEASE CIRCLE)
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

WHAT ARE YOUR **GOALS FOR TREATMENT**?

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE