COMPLETE REHAB
YOUR PHYSICAL THERAPY SOLUTION

Patient Demographic Form

Full Name: _____ Birthday: __/__/___

☐ Male ☐ Female SSN: _____ Do you need an interpreter? Y N

Address: _____

_____

Preferred Appointment Reminders

Phone Numbers: Home: _____ ☐ Text Message ☐ Voice Call

Mobile: _____ ☐ Text Message ☐ Voice Call

Email Address: _____ ☐ Email

Marital Status: ☐ Married ☐ Single ☐ Unknown

Student Status: ☐ Full-time ☐ Part-time ☐ None

Employment Status: ☐ Full-time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ None

<u>Employer Information</u>

Name of Employer: _____

Work Phone: _____

<u>Emergency Contact</u>

Name: _____ Relationship: _____

Phone Number: _____

Whom may we thank for your referral? Name: _____

☐ Physician ☐ Hospital ☐ Event
☐ Employer ☐ Attorney ☐ Friend
☐ Case Manager ☐ Marketing Ad - Print ☐ Former Patient
☐ Adjustor ☐ Marketing Ad - Facebook ☐ Self – Returning patient

_____ Date: _____

Signature

Medical History

Patient Name: _____ Date: _____

Previous Surgeries		
Type of Surgery	**Date of Surgery**	**Details**

Diagnostic Testing		
Test Performed	**Date of Test**	**Details**
ABR/BAER (Brainstem Testing)		
Bloodwork/Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study/Empty Scan		
MRI		
NCV (Nerve Conduction Testing)		
Swallow Study		
Upper Endoscopy		
Xray		
Other:		

Specialists		
Type	**Name**	**Reason**
Allergist		
Audiologist		
Cardiologist		
Developmental Medicine		
Endocrinologist		
ENT		
Gastronterologist		
General Surgeon		
Hand Surgeon		
Internal Medicine		
Nephrologist		
Neuro-Surgeon		
Neurologist		
OBGYN		
Oncologist		
Orthopedic Surgeon		
Pediatrician		
Physiatrist		
Podiatrist		
Psychiatrist/Psychologist		
Rheumatologist		
Thoracic Surgeon		
Urologist		

Medical Conditions:

☐ Alzheimer's	☐ Fibromyalgia	☐ Immunosuppression	☐ Osteoathritis	☐ Rheumatoid Arthritis
☐ Asthma	☐ Headaches	☐ Joint Replacement	☐ Osteoporosis	☐ Substance Abuse
☐ Cancer	☐ Heart Condition	☐ Lupus	☐ Pacemaker	☐ Syncope/Fainting
☐ Cauda Equina	☐ High Blood Pressure	☐ Mental/Cognitive Disorder	☐ Parkinson's	☐ Traumatic Brain Injury
☐ Current Infection	☐ High Cholesterol	☐ Metal Implants	☐ Pregnancy (Current)	☐ Weight Change
☐ Diabetes	☐ History of Falls	☐ Muscular Dystrophy	☐ Prolonged Steroid Use	
☐ Epilepsy	☐ Huntington's	☐ Obesity	☐ Recent Fractures	

Other Conditions (not mentioned above): _____

_____

Medications		☐ Attached Medication List
Medication	**Dose**	**Reason**

Allergies		
Type	**Reaction**	**Severity**

Recent Hospitalization			
Type	**Name of Facility**		**Discharge Date**
Hospitalization			
Skilled Nursing Care (Nursing Home)			
Home Health Care			
Outpatient Therapy (Since Jan. 1st)		**Number of Visits:**	

Social History:

Current Smoker: Y N Packs per day: _____ Year Smoking: _____

Previous Smoker: Y N Years smoke free: _____ Years Smoked: _____

Alcohol: ☐ Often ☐ Occasionally ☐ Never

Recreational Drugs: ☐ Often ☐ Occasionally ☐ Never

Living Situation: ☐ House ☐ Apartment ☐ Stairs in Home

☐ Alone ☐ Family/Roommate

Current Pain Location: _____

Pain Level at its worst: 0 1 2 3 4 5 6 7 8 9 10

Current Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Pain Level at its best: 0 1 2 3 4 5 6 7 8 9 10

Pain Description: ☐ Burning ☐ Sharp ☐ Dull/Achy ☐ Throbbing ☐ Shooting ☐ Numbness/Tingling ☐ Constant

☐ Intermittent ☐ Worse in the morning ☐ Worse in the evening ☐ Other: _____

_____ _____

Patient Signature Therapist Review Signature

Date Reviewed: _____