# Patient Face Sheet

INFO TAKEN BY:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date Of Call | Patient Account # | | | How Did You Find Out About Us? | | | Last Md Visit | | Physical Therapist | |
| Patient Last Name: | | | | First Name: | | | | | Middle | |
| Phone #s and Email Address:  (H) (W) (C) Email : | | | | | | | | | | |
| Emergency Contact: Job Desc:  Ph #s: DOB: Gender: Marital Status: Op Report: | | | | | | | | | | |
| SSN: | | | | Employer: | | | | | | |
| Current Rx Signed on: Receiving Skilled Nursing? Previous Physical Therapy: | | | | | | | | | | |
| Mailing Address: | | | | | | | | | | |
| Treatment Address: | | | | | | | | | | |
| Facility: | | | | | Additional Info: | | | | | |
| Referring MD: | | | | MD to receive notes? | | PCP MD: | | | MD to receive notes? | |
| Frequency: | | | | | | | | | | |
| RX:  **ICD - 9 Diagnosis:**  DOI:  DOS: | | | | | | | | | | |
| Primary Insurance: | |  |  | | Subscriber #: | | |  | |  |
| Adjuster: | |  | Address: | |  | | | Phone #s: | |  |
| Injured Person: | |  |  | | DOB: | | | Relation: | |  |
| Date: | | S/W: | Coverage: | | Deductible: | | | Start / End Date: | | # of Visits: |
| Secondary Insurance: | |  |  | | Subscriber #: | | |  | |  |
| Adjuster: | |  | Address: | |  | | | Phone #s: | |  |
| Injured Person: | |  |  | | DOB: | | | Relation: | |  |
| Date: | | S/W: | Coverage: | | Deductible: | | | Start / End Date: | | # of Visits: |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have reviewed and attest to the accuracy of the information.

SIGNATURE: DATE:

# PATIENT INFORMATION

NAME: OCCUPATION: AGE:

Date of Onset: Injury/problem/surgery:

Height:

Weight:

Briefly state previous treatment, if any:

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | YES | NO |  |  | YES | NO |
| **DIABETES** | |  |  |  | **ALLERGY TO COLD** |  |  |
| **HIGH BLOOD PRESSURE** | |  |  |  | **OTHER ALLERGIES** |  |  |
| **PACEMAKER** | |  |  |  | **PREVIOUS SURGERIES** |  |  |
| **CHRONIC HEADACHES** | |  |  |  | **CIRCULATORY DISEASE** |  |  |
| **KIDNEY PROBLEMS** | |  |  |  | **METAL IMPLANTS** |  |  |
| **SEIZURES** | |  |  |  | **DIZZINESS** |  |  |
| **HERNIA** | |  |  |  | **CANCER** |  |  |
| **ALLERGY TO HEAT** | |  |  |  | **PREGNANT** |  |  |
| **BONE DISEASE** | |  |  |  | **OSTEOPOROSIS** |  |  |
| **BLADDER PROBLEMS** | |  |  |  | **FRACTURES** |  |  |
| **BOWEL PROBLEMS** | |  |  |  | **RECENT WEIGHT LOSS** |  |  |
| **PINS AND NEEDLES** | |  |  |  | **NERVOUS DISORDER** |  |  |
|  | **PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME** | | | | |  |  |

If YES to any of the above, please explain and give appropriate details:

Are you presently taking any medications? YES NO If YES, please list your medications and for what conditions:

Have you had any x-rays, CAT scene, MRI’s, or other diagnostic tests for your recent order? YES NO If YES, please explain the findings as you understand them:

Is there anything else you think we should know about your general health, or current condition? Please explain and if, necessary, we can talk about it:

PHYSICAL THERAPIST SIGNATURE: DATE: