CAHILL PHYSICAL THERAPY, INC

PATIENT INFORMATION

PATIENT NAME: ____

ADDRESS:____

CITY:____ **STATE**: __________ **ZIP**: ____________________

PHONE: (H)______________________ (W) ____________________________ (C)__________________________

SOC. SECURITY #: _________________________________ **SEX**: ☐ MALE ☐ FEMALE **DOB**: ___/____/_______

OCCUPATION: _______________________________________ **EMAIL**: _______________________________________

WOULD YOU LIKE EMAIL/TEXT ALERTS? ☐ Text ☐ Email ☐ NO

EMERGENCY CONTACT: ☐ **SPOUSE** ☐ **PARENT** ☐ **GUARDIAN** ☐ **OTHER** **_____________** (CHECK ONE):

NAME: ____ PHONE NUMBER: ______________________________

INJURY INFORMATION:

DATE OF INJURY: _______/_______/__________ SURGERY?: ☐ YES ☐ NO DATE: ________/________/__________

PRESENT ILLNESS OR INJURY/CONDITION: ____

____

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR? ☐ YES ☐ NO HOW MANY TREATMENTS?: _________________

HAS THIS PROBLEM OCCURRED IN THE PAST? ☐ YES ☐ NO

PAST MEDICAL HISTORY (Please check any and all that apply):

☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE
☐ EPILEPSY OR CONVULSIONS
☐ DIABETES
☐ DIZZINESS/VERTIGO
☐ TUBERCULOSIS (TB)
☐ ARE YOU PREGNANT?
☐ RHEUMATIC FEVER
☐ STROKE/CVA
☐ KIDNEY OR BLADDER ISSUES
☐ TUMOR OR CANCER
☐ RESPIRATORY DISEASE
☐ HEPATITIS: TYPE ___________
☐ DO YOU HAVE SURGICAL IMPLANTS? _____________
☐ ASTHMA
☐ PNEUMONIA OR EMPHYSEMA
☐ HIV/AIDS
☐ PACEMAKER?

SURGERY (LIST ALL PREVIOUS OPERATIONS AND INDICATE APPROXIMATE DATE OR AGE): ______________________________

____

____

FRACTURES OR OTHER SERIOUS INJURIES: ____

____

MEDICATION (PLEASE LIST ALL CURRENT MEDICATIONS): ____

____

COMMENTS: ____

SIGNATURE: ____ **DATE**: _________________________