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**: _____