



RETURNING PATIENT INFORMATION
(WITHIN 12 MONTHS)

NAME: _____ **DATE:** _____
(LAST) (FIRST) (M.I.)

HAVE YOU HAD ANY CHANGE IN:

_____ **ADDRESS?** _____
(STREET) (CITY) (STATE) (ZIP)

_____ **PHONE #'S?** _____
(HOME) (CELL) (WORK)

_____ **EMPLOYMENT?** _____
(NAME OF NEW EMPLOYER)

_____ **INSURANCE?** _____
(NAME OF CARRIER) (POLICY HOLDER'S NAME)

_____ **REFERRING PHYSICIAN?** _____
(NAME) (NEXT APPT. DATE)

_____ **PRIMARY CARE PHYSICIAN?** _____
(NAME) (NEXT APPT. DATE)

PT PLUS MAY SEND NOTIFICATIONS VIA TEXT MESSAGING TO MY MOBILE PHONE NUMBER AND PT PLUS MAY LEAVE MESSAGES AT MY PHONE NUMBERS.

EMAIL: _____

PT PLUS MAY CONTACT ME AT THIS EMAIL FOR EDUCATIONAL MATERIALS AND/OR REMINDERS.

Please list any **NEW** medications, vitamins or supplements that you are currently taking:
Type: _____ Dosage: _____ Reason: _____
Type: _____ Dosage: _____ Reason: _____

Please list any **NEW** illnesses, traumas, surgeries, injuries, or hospitalizations. This includes motor vehicle accidents, work injuries, sports injuries, pregnancies/childbirth etc.
Type: _____ Date: _____ Type: _____ Date: _____
Type: _____ Date: _____ Type: _____ Date: _____

Have you had any recent falls? Yes/No More than twice in the past 12 months Yes/No

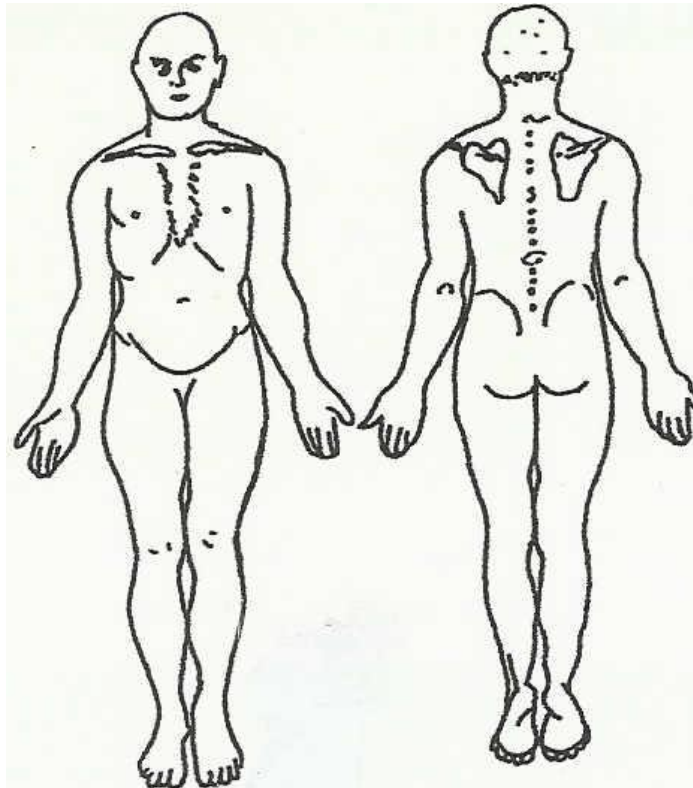
Have you suffered from any **NEW** medical issues that your therapist should be aware of? Yes/No
If yes, please explain:

Current Condition (why you are here today))

What Body Part are we treating? _____
When/How did this problem begin? _____
Have you ever had this problem before? Yes/No _____
What makes the problem worse? _____ Better? _____
Have you had previous treatment or therapy for your current condition? Yes/No _____
Location: _____ Dates: _____ Number of visits: _____
What are your goals of physical therapy? _____
Are you currently working? Yes/No _____ If no or restricted, please describe: _____
X-Ray/MRI Results _____

Pain Diagram:

Please shade in areas of pain



Pain Scale:

Please indicate the amount of pain you are experiencing

(minor) _____ (worse possible)
1 2 3 4 5 6 7 8 9 10

Patient: _____
Date: _____

Therapist: _____
Date: _____