Patient Medical Information Form

PATIENT INFORMATION:

Patient Name: _____

Address: _____

_____

City: _____ St. _____ Zip_____

Home Phone: _____ Cell Phone: _____

Patient's Date of Birth: _____ Social Security Number: _____

Gender: M F (circle one) Marital Status: S M D W (circle one)

Patient's Email Address: _____

Patient's Employer: _____

Address:_____ City: _____ State/Zip:_____

Employer Phone:_____

Primary Insurance: _____

Insured Person (who carries/provides the insurance): _____

Relation to patient: self/spouse/parent/other (circle one) Insured's DOB _____Insured's SSN _____

Other Insurance (if available):

Insured Person (who carries/provides the insurance): _____

Relation to patient: self/spouse/parent/other (circle one) Employer: _____

If patient is a minor:

Parent Name: _____

Emergency Contact:

Name: _____

Relation to patient: _____

Home Phone: _____ Cell Phone: _____

How did you hear about Montgomery Physical Therapy? _____

_____

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MEDICAL INFORMATION:

Date of injury: ____/_____/_____ Date of surgery: ____/_____/_____

Cause of injury: _____

Is this injury a result of: WORK AUTO OTHER_____ (circle one)

Major complaint? _____

List all the doctors you have consulted with for this injury:

_____

_____

List past treatments you have had for this injury including surgeries and their dates:

_____

_____

_____

_____

MEDICATIONS: (prescription and over-the-counter)

[ ] Aspirin
[ ] Pain Medications (Tylenol (acetamenophin), Advil (ibuprofen), Aleve (naproxen sodium), etc)
[ ] Muscle Relaxers
[ ] Anti-inflammatory medications
[ ] Insulin
[ ] Blood Thinners
[ ] Blood Pressure Medications
[ ] Others (please list)_____

_____

_____

_____

_____

Please list any other information you feel we may need to know before beginning physical therapy:_____

_____

_____

_____

_____