PATIENT INFORMATION FORM

Name: _____ Height: _____ Weight: _____

Family Physician: _____

Work Status: □ Working □ Not Working
□ Part Time □ Full Time
□ Light Duty □ Full Duty

Major Job Requirements:
□ Lifting _____ lbs. □ Push/Pull _____ lbs. □ Sitting _____ hrs.
□ Driving _____ hrs. □ Standing _____ hrs. □ Crawling _____ hrs.

How many times per week did you exercise prior to injury? _____

How many times per week do you exercise presently? _____

Do you smoke? □ Yes, how much _____ □ No □ Quit, _____ years

Have you had your heart tested within the last year? □ Yes, results _____ □ No

For Females: Are you pregnant? □ Yes □ No

Check the boxes you currently have or in the past have had problems with:

□ Diabetes
□ Cancer
□ High Blood Pressure
□ Low Blood Pressure
□ High Cholesterol
□ Heart Problems
□ Osteoporosis
□ Headaches
□ Seizures
□ Fainting
□ Chest/neck/arm pain not related to current injury.
□ Allergies _____
□ Other _____
_____

Medications you are currently taking: _____

Have you had prior physical therapy treatment? □ Yes (if Yes, please complete below) □ No

Diagnosis/Area treated: _____ Treatment Dates: _____ # of visits: _____

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Diagnosis/Area treated: _____ Treatment Dates: _____ # of visits: _____

Signature: _____ Date: _____
Patient or Patient's Parent or Legal Guardian