TAYLOR
PHYSICAL THERAPY

Name_____ Birth Date_____ Age_____

Home Address_____ City_____ State____ Zip_____

Home Phone _____ Cell Phone _____

Email address_____ May we contact you by email? Yes No

Where Employed _____ Work Phone _____

Spouse's Name _____ Employer _____

Emergency Contact Person _____ Phone _____

Who is your insurance provider? _____

Are you currently being seen by a Home Health Agency? _____
Name of Agency_____

Have you been treated by a physical, occupational, speech therapist, or chiropractor at any facility within this calendar year? ___Yes ___No If so, number of visits_____

Is your injury: Work related? ___Yes ___No Motor vehicle accident? ___Yes ___No

Date symptoms started _____

Brief description of injury or illness_____

_____

What are your goals for therapy? _____

_____

Do you have or have you had any of the following?

___Heart Problems	___Diabetes	___Seizures
___Pacemaker	___Kidney Disease	___Dizziness/Vertigo
___High/Low Blood Pressure	___Cancer	___Depression
___Circulatory Problems	___Hepatitis	___Mental Illness
___COPD/Emphysema	___Stroke	___Hearing Difficulties
___Asthma	___Neurologic Conditions	___Visual Difficulties
___History of Smoking	___Blood Thinner	___Rheumatoid Arthritis
___Fibromyalgia	___Blood Clots	___Other Arthritic Conditions
___Anemia	___Back pain/sciatica	___Dementia
___Osteoporosis	___Artificial Joints/Implants	___Currently or possibly pregnant

Fall History: Number of Falls within the last year __1 __2 __2+
Did a fall result in injury? ___Yes ___No

Special Tests: ___X-ray ___Bone Scan ___CT Scan ___ MRI

List any prior surgeries: _____

_____

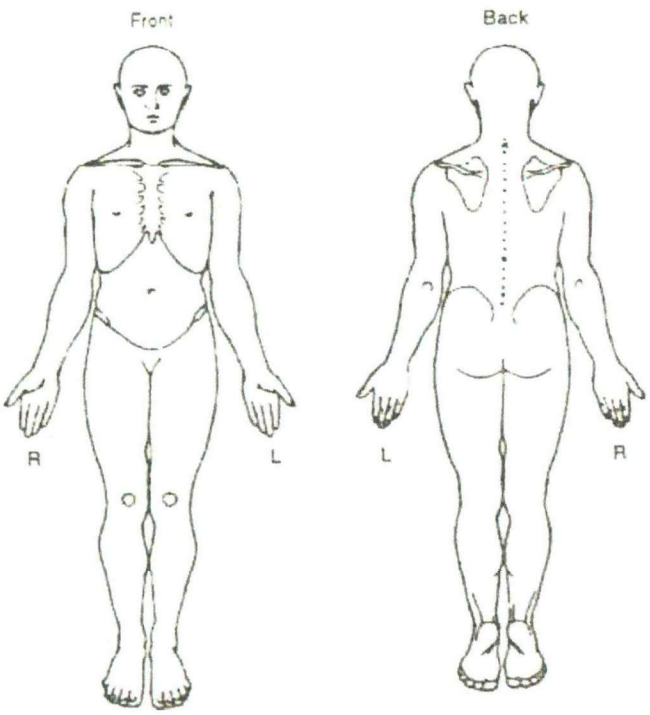
Current Medications _____

_____

(Please fill out back page) Height_____ Weight_____

PATIENT MEDICAL HISTORY

Mark on the diagram below where you are currently experiencing symptoms:



Mark below the intensity of your symptoms.
(Please circle the appropriate number)

0= no symptoms, 10= worst possible symptoms

Currently:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

How restricted are you in your normal activities?
(0 = No Limitations; 10 = Totally Disabled)

0 1 2 3 4 5 6 7 8 9 10

Work capabilities since your injury:

_____ No Work Limitations
_____ Some Work Limitations
_____ Unable to Work
_____ N/A (Child, Student, Retiree, Disabled)

How often do you have these symptoms?
(Please check one below)

_____Constantly (24 hours/day)
_____Occasionally (6-12 hours/day)
_____Frequently (12-23 hours/day)
_____Not frequently (0-6 hours/day)

Please list other treatment you have received for this condition _____
_____
_____

How did you hear about Taylor Physical Therapy? _____

INFORMED CONSENT

I hereby authorize treatment to be administered after evaluation according to the therapist's discretion. This may include, but not limited to, spinal or joint traction, tapping techniques, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I hereby consent and authorize Taylor Physical Therapy to utilize my picture for our medical records. I understand that the necessary procedures to be provided will be explained along with the risks and benefits.

Patient's Signature _____Date_____

Parent or Personal Representative_____Date_____