WAVERLYHEALTH CENTER

Patient Sticker

TAYLOR PHYSICAL & OCCUPATIONAL THERAPY
OT PATIENT MEDICAL HISTORY

_____ New Patient _____ Established Patient

Name _____ Birth Date _____ Age _____

Where Employed _____

Phone _____

May we contact you by email? _____Yes _____No Email Address _____

Have you been treated by a physical, occupational or speech therapist, or chiropractor at any facility within this past calendar year? _____Yes _____No If so, number of visits _____

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

Brief description of injury or illness _____
_____
_____

Date symptoms started _____

Is your injury: Work related? _____Yes _____No Motor vehicle accident? _____Yes _____No

What are your goals for therapy? _____
_____

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

___Heart problems	___Diabetes	___Artificial joints/implants
___Pacemaker	___Kidney disease	___Seizures
___High/low blood pressure	___Cancer	___Dizziness/vertigo
___Circulatory problems	___Hepatitis	___Depression/mental illness
___COPD/emphysema	___Tuberculosis	___Stroke
___Asthma	___Rheumatic fever	___Hearing/visual difficulties
___Shortness of breath	___Multiple sclerosis	___Rheumatic arthritis
___Chronic ulcer	___Blood clots	___Other arthritic conditions
___Anemia	___Back pain/sciatica	___Dementia
___History of smoking	___Osteoporosis	___Currently or possibly pregnant

Have you fallen 2 or more times within the last year? _____Yes _____No

List any other medical information or special tests you've completed that you believe would be beneficial for us to be aware of _____
_____

Current Medications _____
_____

Weight _____ Height _____

(PLEASE FILL OUT BACK PAGE)

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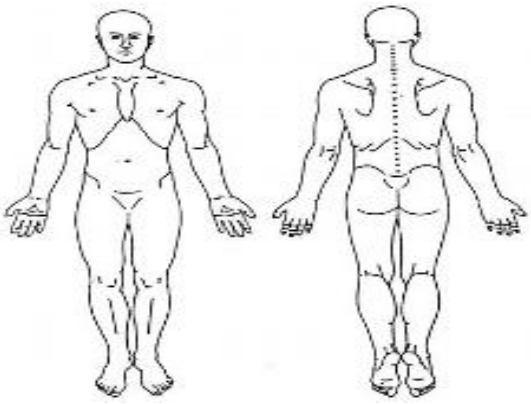
OT PATIENT MEDICAL HISTORY

Mark on the diagram below where you currently are 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 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 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, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I understand that the necessary procedures to be provided will be explained along with the risks and benefits. We utilize a therapy dog in our clinic so please let us know if you have a known allergy.

Patient's Signature _____ Date _____