VILLAGE
PHYSICAL THERAPY

Patient Name _____ Date of Birth _____/_____/_____
Preferred name _____
Address _____ Phone: Home (____)_____/_____
_____ Cell (____)_____/_____
Email_____ Work (____)_____/_____
Which do you wish us to use for communication, including appointment reminders (check all that apply):
Email_____ Home phone_____ Cell_____ Work_____ Address_____

Emergency Contact_____ Phone: (____)_____/_____
Relationship_____
Insurance Subscriber's Name (primary cardholder)_____
Subscriber's Date of Birth _____/____/_____
If patient is a minor, who is responsible _____
Relationship_____
Date of Injury _____
Was your injury the result of a motor vehicle accident?_____ If yes, in which state?_____

How did you hear about us?_____

Last Physical ____/____/_____
Right or left hand dominant_____ Height_____ Weight_____

Check if you have been diagnosed with any of the following:

Arthritis_____
Asthma _____
Cancer_____
Depression_____
Diabetes_____
Fracture/Dislocation_____
Head Injury_____
Heart Conditions_____
High Blood Pressure_____
Kidney Problems_____
Liver Trouble_____
Lung Problems_____
Low Bone Density_____
Neurologic Problems (stroke)_____
Poor Circulation_____
Seizures_____
Stomach Problems (ulcer)_____
Thyroid Problems_____
Men Only: Prostate Disease _____
Women Only: Pregnant _____
Endometriosis _____
Pelvic Floor Dysfunction _____

Patient Name _____ Date of Birth _____/_____/_____

Check if you have RECENTLY experienced:

Falls, 2 or more in the past year _____

Any fall with injury in the past year_____

Bowel/Bladder changes_____

Constant Pain_____

Fever (chills)_____

Unexplained weight loss/gain_____

Unexplained fatigue_____

Unexplained joint pain/swelling_____

Night pain_____

Numbness/Tingling_____

Cough_____

Shortness of Breath_____

New episodes of Headaches_____

Visual Changes_____

Hoarseness_____

Hearing difficulties_____

Chest Pain_____

Dizziness_____

Weakness_____

Difficulty Walking_____

Smoking Cigarettes _____

Other Medical Conditions _____

_____

Hospitalizations/Surgeries:	**Date**		**Date**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications:	**Name**	**Dosage**	**Name**	**Dosage**
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Allergies _____

Communication barriers/learning style preferences_____

_____

Reviewed on _____ by _____