SoFLo PT
South Florida Physical Therapy & Sports Rehab
Move Better, Move More.

PATIENT INFORMATION

First Name: _____ Last Name: _____ M: ___ F: _____

Date of Birth: _____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell #: _____-_____ Home#: _____-_____ Best time & place to reach you: _____

Emergency Contact: _____ Phone#: _____-_____

Email: _____ Marital Status: Single_____ Married _____

Employer's Name: _____ Occupation: _____

Injury Date: _____Surgery Date: _____ Injury: Work or Auto related? _____

Referring Physician Name: _____ Phone #: _____ -_____

Allergies or Medical Precautions: _____

Who can we thank for this referral? _____

Please bring the prescription from your physician and a copy of your insurance card & Picture ID or any other medical claim information if your injury is work or auto related. Please be sure to wear appropriate clothing based on the location of your injury. For example, shorts for a lower extremity injury (knee or ankle), loose or sleeveless shirt for a shoulder injury.

INSURANCE INFORMATION

Insurance Co. Name: _____ Policy#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____ SS#: _____-_____-_____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Employer's Name: _____

PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other _____		

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night pain	Headaches

How have you been sleeping at night? Fine Disturbed only with medication

What is your smoking status? __never__past ___current; frequency _____

Current History:

What date (approximately) did your present symptoms start? _____

Surgery date or injury date? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed? getting better about the same getting worse

What makes your symptoms better? _____

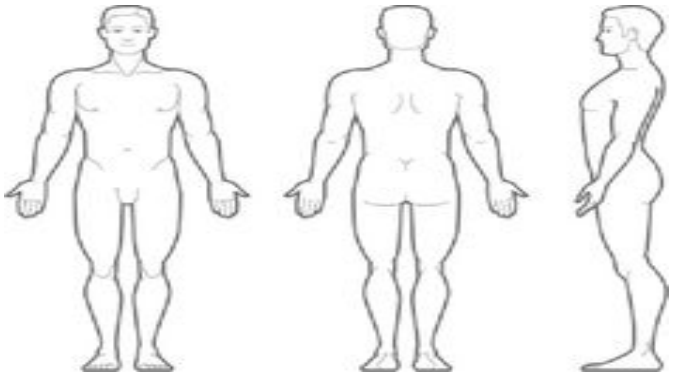
What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) _____

What treatments have you received for this problem so far? _____

Body Chart:

Mark the areas where you feel your symptoms.



On the scale below, circle the number which best represents the average level of pain you have experienced

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10

Cannot do anything — Able to do everything

PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

1) _____
2) _____
3) _____

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT, osteopath, etc.)? Yes / No If yes, please describe the reason. _____

_____

Have you had any falls in the past year? __Yes __NO

List any other injuries you have had that required medical attention. _____

_____

What are your personal goals for therapy at this time? _____

_____

CONSENT: The information I have provided above is accurate and complete.

_____ _____
(signature) (date)

THANK YOU FOR YOUR PATIENCE AND VALUABLE TIME!!

DR NOTES

_____

_____

_____

_____

_____