FALMOUTH PHYSICAL THERAPY

Patient information

Patient name:_____Social Security #:_____

Local address:_____P.O.Box:_____

City/State/Zip:_____

Home phone:_____Work/Cell phone:_____

Age:_____Birthdate:_____Sex;Male___Female_____Your Occupation:_____

Employer:_____Employer's address_____

Person to Notify in case of emergency:_____Phone:_____

Insurance Company:_____Policy #:_____

Attorney:_____

Referring Physician:_____Primary Care Physician:_____

Follow up visit date:_____

Medical History;

Problem we are treating:_____Date of accident:_____

Has condition been treated before?_____If yes,explain:_____

Have you had any surgeries?_____Type and date:_____

Medications. Please list:_____

List any known drug allergies:_____

If female, is there a chance that you may be pregnant?_____

Do you have any metal implants or pacemaker?_____

Do you have any disorders of the following?(please explain):

Head, eyes, ears, throat:_____Lungs:_____

Blood pressure:_____Kidneys:_____

Stomach; Liver;
Intestines:_____

Do you presently have or have you had in the past?

MS_____Diabetes_____Osteoporosis_____

Stroke_____Joint replacement_____

Neurological disease_____

Cancer (please explain)_____

Signature_____Date_____