PATIENT_____DATE OF BIRTH_____

REFERRING
PHYSICIAN_____PHONE_____

PRIMARY CARE PHYSICIAN
_____PHONE_____

WOULD YOU LIKE A COPY OF YOUR EVALUATION SENT TO YOUR PCP? Y / N

EMERGENCY CONTACT_____ PHONE
_____

PAST MEDICAL HISTORY

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

- Cardiovascular disease (CABG, sickle cell anemia, Heart valve problems, PACEMAKER, arrhythmia, heart attack)
    - Other_____

- Diabetes type I
- Diabetes type II
- Fibromyalgia
- Alzheimer's
- High Cholesterol
- High blood pressure
- Stroke
- Cancer:
- Lupus
- Osteoarthritis:
- Rheumatoid arthritis
- Epilepsy or seizure disorder
- Parkinson's Disease
- Lung disease (asthma, emphysema, COPD)
- AIDS and HIV positive
- OTHER_____

Surgical History

- No
- Yes, explain:

Physical Therapy History

- No
- Yes, explain:

Pregnant?

- No
- Yes

Adverse reactions to heat or cold?

- No
- Yes

FOOD OR DRUG ALLERGIES (PLEASE LIST)
• CHECK BOX IF NONE

CURRENT MEDICATIONS (LIST MEDICATIONS OR GIVE RECEPTIONIST A PREPARED LIST)		• CHECK BOX IF NONE
MEDICATION **(prescription, vitamin, over the counter)**	**STRENGTH** **(example: 50mg)**	**DIRECTIONS (2 pills in the morning)**

PLEASE LIST ANY FURTHER INFORMATION THAT WE SHOULD BE AWARE OF PRIOR TO TESTING AND/OR TREATNG YOUR CONDITION:

I AFFIRM THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF BARSTOWN RD. PHYSICAL THERAPY GROUP, INC.'S NOTICE OF PRIVACY PRACTICES AND THAT I MAY REQUEST A COPY AT ANY TIME.

_____ _____

Patient Signature Date