



21195-B IH-35 North, Suite 201
Kyle, Texas 78640
512.268.0000 voice
512.268.0004 fax

Patient Information

Name: _____ Date: _____

Address: _____

Home: _____ Work: _____ Cell: _____

Male Female Married Child Date of Birth: _____ Age: _____

SSN# (Medicare, Tricare and Workers Comp only): _____

E-mail: _____

Emergency Contact: _____ Number: _____

Is this treatment due to a Motor Vehicle Accident or Work Injury? Yes No Date of Injury: _____

Policy Holder Information for Personal Insurance or Medicare

Name: _____ Relationship to Patient: _____

Address: _____

Home: _____ Work: _____ Cell: _____

Male Female Date of Birth: _____

SSN# (Medicare and Tricare only): _____

Employer: _____

Primary Insurance Carrier: _____

ID: _____ Group: _____ Phone Number: _____

Co-Pay: _____ Co-Insurance: _____ Deductible: _____ Max PT PCY: _____

Secondary Insurance Carrier: _____

ID: _____ Group: _____ Phone Number: _____

Workers' Comp Information / Personal Injury Protection

Employer: _____ Phone: _____

Adjustor: _____ Phone: _____

Claim Number: _____

Treatment Information

Referring Physician: _____ Phone: _____

Date of first doctor visit for this injury: _____ Date of Injury: _____

Have you had surgery for this injury? Yes No Date of Surgery: _____

Current Medications: _____

How would describe your present health? Excellent Good Fair Poor

Have you had any of the following medical or rehabilitative services for this injury?

- | | | |
|---|---|--|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Emergency Room Care |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> MRI | <input type="checkbox"/> X-ray |

If you checked one of the above boxes, how many visits? _____

What are the specific goals you would like to accomplish with physical therapy? _____

Do you have a follow-up scheduled with your doctor? Yes No Please provide date: _____

Patient Health Information

Have you ever had any of the following? Please check all which apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease / Angina | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Weight/Energy Loss |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack/Surgery | |
| <input type="checkbox"/> Blood Clot/Emboli | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Are you pregnant? |
| <input type="checkbox"/> Bowel/Bladder Issues | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Do you smoke? |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Mental Disorders | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis | Injury and/or Surgery: |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Neck Date: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pins/Metal Implants | <input type="checkbox"/> Shoulder Date: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Elbow Date: _____ |
| <input type="checkbox"/> Emphesema | <input type="checkbox"/> Shortness of Breath / Chest Pain | <input type="checkbox"/> Back Date: _____ |
| <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Knee Date: _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Leg Date: _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Ankle Date: _____ |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Varicose Veins | |

DIAGRAM TO BE FILLED OUT IN OFFICE AT FIRST VISIT

Please mark the location(s) of your current symptoms on this diagram. If symptoms, which pertain to your current injury, are in more than one area, please be sure to include all areas on the diagram.

