PATIENT INFORMATION

Last Name ___________________ Legal First Name ___________________ Date of Birth_____________

Preferred Name ____ Gender ☐ Male ☐ Female

Address _____________________________ Referring Doctor ____________________________________

_____________________________ Diagnosis ________________ Date Problem Began ________

Home Phone _________________ Work phone ___________________ Cell Phone ___________________

Email ____

Have you had Speech Therapy, OT, or PT this calendar year? ___ Yes ____ No

If So: How Many Visits? _______________ Where? _______________________

Marital Status: ____Single ____Divorced ____Married ____Widowed

Spouse's Name______________________ Spouse's DOB __________________

Spouse's Cell phone __________________ Work phone____________________

How would you like appointment reminders?

__ Text
__ Email
__ Neither

Cell Phone Carrier
(If text preferred)

____

INSURANCE

Primary Insurance ________________________________ **(Please provide a copy of your insurance card)**

Name of Subscriber ________________________ Relationship ___________________________________

Subscriber's Date of Birth ___________________

Secondary Insurance ______________________________ **(Please provide a copy of your insurance card)**

Name of Subscriber ________________________ Relationship __________________________________

Subscriber's Date of Birth ___________________

Worker's Compensation and/or Accident (if yes, which one?):____________________________________

Name of Employer ____________________________Employer Phone Number ________________

Employer's Address ____

Name of Claim Adjuster ____

Worker's Comp. Phone # (for claim adjuster) ____

IN CASE OF EMERGENCY

Emergency Contact (other than spouse) ____

Phone Number ____

How did you hear about our clinic? ____

FOR OFFICE USE ONLY

Height _____ Weight ______ BMI ______

MEDICAL HISTORY FORM

Do you have now or have you ever had any of the following conditions? (Please check Yes or No)

CARDIOVASCULAR

Yes No

☐ ☐ High Blood Pressure
☐ ☐ Chest Pain
☐ ☐ Heart Attack
☐ ☐ Mitral Valve Prolapse
☐ ☐ Abnormal EKG / Stress Test
☐ ☐ Taking Anticoagulants
☐ ☐ Stroke
☐ ☐ Defibrillator
☐ ☐ Pacemaker

PSYCHIATRIC

Yes No

☐ ☐ Depression
☐ ☐ Anxiety

PULMONARY

Yes No

☐ ☐ COPD or Emphysema
☐ ☐ Asthma
☐ ☐ Shortness of Breath
☐ ☐ Use Oxygen (O2) at home
☐ ☐ Tobacco Use

MUSCULOSKELETAL

Yes No

☐ ☐ Pain in Joints
☐ ☐ Swelling in Joints
☐ ☐ Artificial Joint
☐ ☐ Osteoporosis / Osteopenia

OTHER SYSTEMIC

Yes No

☐ ☐ Cancer
☐ ☐ Diabetes
☐ ☐ Thyroid Abnormality
☐ ☐ Bladder Problems
☐ ☐ Bleeding Disorder
☐ ☐ History of HIV
☐ ☐ History of Hepatitis
☐ ☐ Pregnancy (or trying?)

NEUROLOGIC

Yes No

☐ ☐ Fainting / Seizures
☐ ☐ Dementia
☐ ☐ Parkinson’s

Is there anything else you would like for your therapist to know? Yes No

If yes, explain ____

Do you have any allergies? ____

****List all medications you are currently taking (include OTC, herbals, supplements, vitamins, or attach list):**

Name	Dosage	How often?	How taken (oral/
1.			
2.			
3.			
4.			
5.			
6.			

Please list any surgical procedures you have had.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Print Name: ________________________________

Signature: __________________________________ Date: ___________________________