JOHNSON & HAYES
PHYSICAL THERAPISTS

Patient Information

NAME
Last_____ First _____ Middle_____

Name you go by: _____

Address_____

City_____ State_____ Zip_____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Cell Number: (_____) _____ - _____

Sex: (Circle One) Female Male Date of Birth: _____ / _____ / _____

Social Security Number: _____- _____ - _____ Marital Status:_____

Employer_____ Occupation: _____

Emergency Contact

Name: _____ Phone#:_____

Relationship to Patient: _____

History of Injury

Explain reason for today's visit_____
_____
_____

Date of Injury or Date Symptoms Began_____(***required for insurance)**

If today's visit is post-op, date of Surgery_____

Is today's visit related to or covered under **Workman's Compensation?** _____
Auto Accident? _____
If Auto, what state did it occur? _____

Has the patient had Physical Therapy at any other facility this year?

(Circle One) YES NO

If so, where? _____ How many visits? _____

Insurance Information

Insurance Company: _____

Policy or Contract Number: _____

Group Number: _____

Insurance Subscriber's Information

(Complete only if the patient is NOT the insurance subscriber)

NAME
Last_____ First _____ Middle_____

Relationship to patient: _____

Address_____

City_____ State_____ Zip_____

Insurance Subscriber's Sex: (Circle One) Female Male

Date of Birth: _____ / ____ / _____

Social Security Number: _____- _____ - _____

Employer_____ Occupation: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Mobile Number: (_____) _____ - _____

MEDICAL HISTORY FORM

Patient Name: _____ Referring Physician: _____

Family Physician: _____

Are you allergic to any medications? Y or N

List all medications you are allergic to: _____

List medications you are currently taking: _____

_____

How did you hear about Johnson & Hayes Physical Therapists?

_____

Do you now have or have you ever had any of the following?
Please write Yes or No
Asthma, Bronchitis or Emphysema
Shortness of Breath
Pacemaker
High Blood Pressure
Any type of heart problems
Cancer or Chemotherapy/Radiation
Arthritis
Sleeping Problems
Emotional/Psychological Problems
Bowel or Bladder Problems
Severe or Frequent Headaches
Vision/Hearing Difficulties
Numbness/Tingling/ Dizziness
Varicose Veins
Allergies
Any Pins or Metal Implants
Joint Replacement
Neck/Shoulder/Hand/Elbow Injury
Back/Knee/Leg Injury
Ankle/Foot Injury
Are you pregnant?
Diabetes/Blood sugar problems
Are you allergic to latex?
Osteoporosis

PATIENT/GUARDIAN SIGNATURE: _____

DATE_____