NASSAU PHYSICAL THERAPY date:__________
Patient Information & Medical History

NAME_________________________________BIRTHDATE________________ AGE___________

ADDRESS:____

PHONE #'S*: Home____________________ Cell______________________ Work______________

E-MAIL ADDRESS: ____

SS#_________________________ OCCUPATION / EMPLOYER*________________________________

REFERRING DR:______________________ MY **NEXT APPT** w/ REFERRING DR IS: _________

CONDITION/ REASON FOR PHYSICAL THERAPY:___________________________________

DATE OF INJURY :______________ Date of surgery-***IF applicable***:________________

Was injury due to accident at: WORK / HOME / AUTO / OTHER

INSURANCE COMPANY NAME(S):____
IF Worker's Comp: Claim#_____________________________ Case Mgr______________

************ Please Provide 2 EMERGENCY CONTACT NAMES & PHONE #s ***************

Name______________________________Relationship___________Phone_____________________

Name______________________________Relationship___________Phone_____________________

ARE YOU ***PRESENTLY*** RECEIVING HOME HEALTH CARE for ***ANY*** REASON? *NO* *YES*

HAVE YOU RECEIVED HOME HEALTH CARE FOR ***THIS*** CONDITION? *NO* *YES*
IF YES – *WHEN WERE YOU DISCHARGED FROM HOME HEALTH?* ___________________________
NAME OF HOME HEALTH AGENCY:____

Please check *ALL* that apply & *IF* necessary - briefly describe

HI BLOOD PRESSURE			DIABETES		
STROKE-C.V.A.			IMMUNE DISORDER		
HEART PROBLEMS			EPILEPSY		
CANCER			ARTHRITIS		
BREATHING PROBLEMS			JOINT PROBLEMS		
COMMUNICABLE DISEASE			METAL IMPLANTS		
VISUAL PROBLEMS			HEARING PROBLEMS		
NUMBNESS / TINGLING			**WOMEN*-PREGNANT?		*DUE DATE:*

Previous MAJOR Hospitalizations/ *Dates* of Surgeries:
CURRENT MEDICATIONS:
ALLERGIES:

OTHER Conditions ____

*Usual Recreational Activities:*____

PATIENT SIGNATURE_____________________________ PT:___________________ DATE:_____________