PATIENT INFORMATION

What is your full name? _____

Date of birth _____ Email _____

Address _____

_____

Home Phone _____ Work phone _____

Cell phone _____ Doctor's Name_____

Diagnosis _____

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 DOB _____

Spouse's Cell phone _____ Work phone_____

INSURANCE

Responsible Party's Employer _____

Employer's Phone # _____

Primary Insurance_____

Policy Number _____Group Number _____

Name of Subscriber _____ Relationship _____

Subscriber's Date of Birth _____

Secondary Insurance _____

Policy Number _____Group Number _____

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

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? _____

BIRMINGHAM PHYSICAL THERAPY
& SPORTS MEDICINE

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? _____

Please list all medications you are currently taking (including OTC and herbals, or attach list):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any surgical procedures you have had.

1. _____
2. _____
3. _____
4. _____

Print Name _____

Signature _____ Date _____