MEMORIAL
Belleville, Illinois 62226

PATIENT HISTORY

Name:_____ Date:_____
Referring Physician: _____
Next appointment with your doctor:_____ Height:_____ Weight:_____

Are you currently receiving any service from a Home Health Agency? ❑ ***Yes*** ❑ ***No***

Are you currently or possibly pregnant ? ❑ ***Yes*** ❑ ***No***

Preferred Mode of Learning: ❑ Listen ❑ Written ❑ Demonstrated ❑ Handouts

Please list any other past/present medical problems/major surgeries: _____

_____

Would you be interested in nutritional counseling? ❑ Yes ❑ No

What is your **main complaint or problem** that brings you here? _____

When did it start? _____

How did it start?_____

_____

Where is your pain located? (Please shade in areas on diagram)

Have you had any recent tests for this condition?_____

Have you had any previous treatment for this condition?_____

Has the doctor given you any specific limitations/ or guidelines to follow?_____

Are you currently employed? ❑ Yes ❑ No

❑ Full−time ❑ Part−time ❑ Light Duty ❑ Medical Leave

❑ Retired ❑ Not working ❑ Disabled

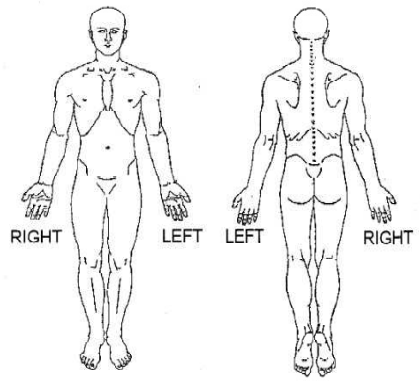
Occupation:_____ How many years on present job?_____

Was this a work related injury? ❑ Yes ❑ No

What is your current work level? ❑ Heavy ❑ Moderate ❑ Light

Do you live alone? ❑ Yes ❑ No Do you have steps? ❑ Yes ❑ No How many?____

Have you fallen in the past 6 months? ❑ Yes ❑ No Are you able to drive? ❑ Yes ❑ No



What are your goals for your treatment here?_____

Do you have any objection to you attendant being of the opposite sex? ❑ Yes ❑ No

Do you object to having your exercises done in an open gym with other patient? ❑ Yes ❑ No

_____ _____ _____

Patient Signature Date Therapist Signature

Do Not Write Below This Line

PTEVAL

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