

Physical Therapy Patient History

Name: _____ Date: _____

Gender: _____ Male _____ Female Age: _____

Referring Physician: _____

What condition are you here for? _____

How long have you had this condition? _____

What caused this condition? _____

Have you had this condition before? If yes, what treatment did you receive?

Please list briefly your previous and current medical history:

Please list any medications you are taking at this time?

Whom may we thank for referring you to our facility? _____

Please note it is the patient's responsibility for providing Physiofitness with current physician prescriptions and/or authorizations as required by your insurance company. We will assist you when possible in obtaining these documents, however, please understand that it is the patient's responsibility to provide us with the proper paperwork needed. Thank you for your cooperation.