VISSERS
PHYSICAL THERAPY

PATIENT INFORMATION FORM

TODAY'S DATE: _____/_____/_____

NAME: _____
Last First M. Initial

ADDRESS: _____

CITY: _____ STATE:_____ 9-DIGIT ZIP CODE: _____

PHONE NUMBER : _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____

☐ Male ☐ Female ☐ Child MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

OCCUPATION: _____ ☐ Full-Time ☐Part-Time ☐Retired ☐Other

REFERRING PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE NUMBER: _____

EMERGENCY CONTACT:

NOTIFY: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

INSURANCE COMPANY NAME: _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____/_____/_____

ADDRESS: _____ PHONE NUMBER:_____

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

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MEDICAL HISTORY:

Diagnosis/Reason for therapy: _____

Date of Onset: _____

Date of MD visit: _____

Date of first MD visit for this dx: _____

Date of Surgery: _____

Are you currently receiving Physical Therapy: ☐ Yes ☐ No

If yes: ☐ At Home ☐ Outpatient

Have you had Physical Therapy this year: ☐ Yes ☐ No

If yes: ☐ At Home ☐ Outpatient

Do you have any of the following medical illnesses/concerns?

	YES	NO		YES	NO			
Heart Problems	☐	☐	Seizures	☐	☐	Height		
High Blood Pressure	☐	☐	Pacemaker	☐	☐	Weight		
Cancer	☐	☐	Diabetes	☐	☐	Pregnant	YES	NO
Type:			Type:				☐	☐

MEDICATION: _____

ALLERGIES: _____

Pain Complaint (0-10): At best_____ At worst: _____

What makes your pain or symptoms feel better? _____

What makes your pain or symptoms feel worse? _____

When is your next doctor's appointment: _____

PATIENT SIGNATURE: _____ DATE: _____/_____/_____