535 E North St, Suite C
Bradley, IL 60915
P: (815) 802-7503
F: (815) 802-7514

422 S Governors Hwy #4
Peotone, IL 60468
P: (708) 792-0044
F: (708) 792-0043

341 S Main Street
Clifton, IL 60927
P: (815) 918-5084
F: (815) 918-5090

PATIENT CONTACT INFORMATION

First Name: ____________________ **Middle Initial**: ____ **Last Name**: ______________________

Address: ____

City: ________________________________ **State**: ______________ **Zip Code**: ________________

Home Phone: (   ) ____________________________ **Work Phone**: (   ) ____________________________

Cell Phone: (   ) ____________________________ **Email**: ____________________________________

Date of Birth: ______/______/______ **Age**: _________ years **Sex**: ☐ Male ☐ Female

Height: ___________________________________ **Weight**: ___________________________________

Emergency Contact Name: ____________________________ **Relationship**: __________________

Emergency Contact Phone: (   ) ______________________

How did you hear about our clinic?: ____

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

Name: ____

Address: ____

City: ________________________________ **State**: ______________ **Zip Code**: ________________

Occupation: _________________________ **Work Phone**: (   ) ____________________________

INSURANCE INFORMATION

Primary Insurance Company: ____

Member ID#: ____ **Group #**: ______________________

Policy Holder: __________________________________ **Policy Holder D.O.B.**: _____/_____/_____

Relationship to Patient (if not self): ____

Policy Holder Address: ____

City: ________________________________ **State**: ______________ **Zip Code**: ________________

Policy Holder Phone: (   ) ____________________________

CASE INFORMATION

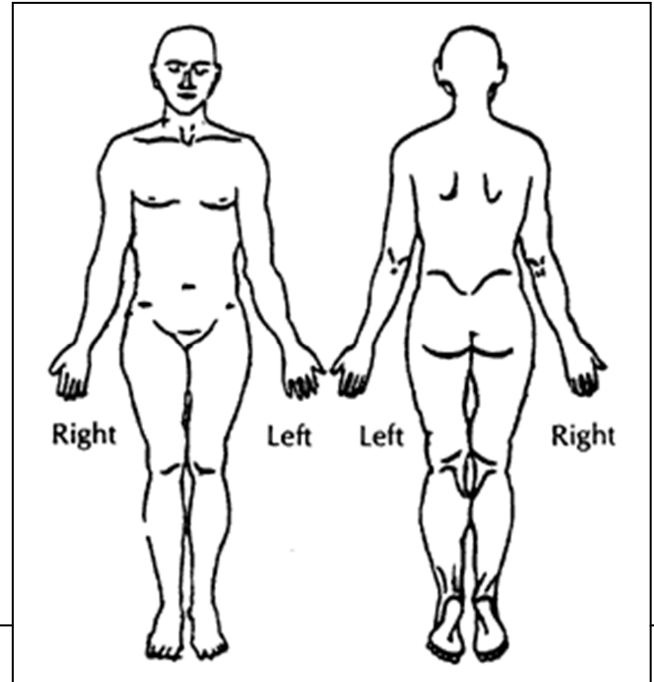
Using the scale to the right, how would you grade your pain in the LAST 48 HOURS?
(*please enter only 1 number on the line behind each question)*

0 NO PAIN
1
2
3
4
5
6
7
8
9
10 WORST PAIN

At best? ___________

At worst? ___________

At the moment? ___________



Describe your pain in the last 48 hours:

□ SHARP □ DULL

□ CRAMPING □ ELECTRICAL

□ LOCALIZED □ RADIATING

In the body chart to the right, please draw the area(s) of discomfort or pain.

Have you fallen in the past year? YES/NO

If so, how many times? ________

Why did you fall? ______________________________

Are you currently receiving any form of Home Health Care? (PT, OT, RN) YES/NO

Describe your symptoms: ______________________________

____

When did your problem begin? Date: ___________ If no date: # of weeks ago:___# of months ago:____

How did your symptoms begin? ______________________________

What eases or makes your problem better? ______________________________

What aggravates or makes your problem worse? ______________________________

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occassionally (26-50% of the day) □ Intermittently (0-25% of the day)

How are your symptoms changing?

□ Getting Better □ Not Changing □ Getting Worse

What tests have you had for your symptoms?

□ X-rays □ MRI □ CT Scan □ Other

Who have you seen for your symptoms?

□ Medical Doctor □ Physical Therapist □ Chiropractor □ No One □ Other

Have you had previous treatment for your symptoms?

□ Physical Therapy □ Chiropractic □ Medication □ Surgery □ Other

In general, would you say your overall health right now is...

□ Excellent □ Very Good □ Good □ Fair □ Poor

MEDICAL HISTORY INFORMATION

Have you had trouble with any of the following?

Cardiovascular: ☐ NO

	Present	Past	No
Poor Circulation	☐	☐	☐
High Blood Pressure	☐	☐	☐
Aortic Aneurysm	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Attack	☐	☐	☐
Chest Pain	☐	☐	☐
High Cholesterol	☐	☐	☐
Pace Maker	☐	☐	☐
Jaw Pain	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Swelling of Legs	☐	☐	☐

Gastrointestinal: ☐ NO

	Present	Past	No
Gallbladder Problems	☐	☐	☐
Bowel Problems	☐	☐	☐
Constipation	☐	☐	☐
Liver Problems	☐	☐	☐
Ulcers	☐	☐	☐
Diarrhea	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Bloody Stools	☐	☐	☐
Poor Appetite	☐	☐	☐

Hematologic/lymphatic: ☐ NO

	Present	Past	No
Hepatitis	☐	☐	☐
Blood Clots	☐	☐	☐
Cancer	☐	☐	☐
Easy bruising	☐	☐	☐
Easy Bleeding	☐	☐	☐
Fever/Chills/Sweats	☐	☐	☐

Integumentary: ☐ NO

	Present	Past	No
Skin Ulcers	☐	☐	☐
Skin Disease	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Rashes	☐	☐	☐

Respiratory: ☐ NO

	Present	Past	No
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of Breath	☐	☐	☐
Emphysema	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐

Ears/Nose/Throat: ☐ NO

	Present	Past	No
Dizziness	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinus Infection	☐	☐	☐
Nosebleed	☐	☐	☐
Sore Throat	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Bleeding Gums	☐	☐	☐

Neurologic: ☐ NO

	Present	Past	No
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Head Injury	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Numbness	☐	☐	☐
Severe Headaches	☐	☐	☐
Pinched Nerves	☐	☐	☐
Parkinson’s Disease	☐	☐	☐
Carpal Tunnel	☐	☐	☐
Spinning/Balance	☐	☐	☐

Psychiatric: ☐ NO

	Present	Past	No
Depression	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Unusual Stress	☐	☐	☐

Constitutional: ☐ NO

	Present	Past	No
Weight Loss/Gain	☐	☐	☐
Energy Level Problem	☐	☐	☐
Difficulty Sleeping	☐	☐	☐

Allergic/Immunologic: ☐ NO

	Present	Past	No
Hives	☐	☐	☐
Immune Disorder	☐	☐	☐
HIV/AIDS	☐	☐	☐
Allergy Shots	☐	☐	☐
Cortisone Use	☐	☐	☐

Genitourinary: ☐ NO

	Present	Past	No
Kidney Disease	☐	☐	☐
Lower Side Pain	☐	☐	☐
Burning Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Blood in Urine	☐	☐	☐
Kidney Stone	☐	☐	☐

Musculoskeletal: ☐ NO

	Present	Past	No
Gout	☐	☐	☐
Arthritis	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Weakness	☐	☐	☐
Osteoporosis	☐	☐	☐
Broken Bones	☐	☐	☐
Joints Replaced	☐	☐	☐

Endocrine: ☐ NO

	Present	Past	No
Thyroid Disease	☐	☐	☐
Diabetes	☐	☐	☐
Hair Loss	☐	☐	☐
Menopausal	☐	☐	☐
Menstrual Problems	☐	☐	☐

Eyes: ☐ NO

	Present	Past	No
Glaucoma	☐	☐	☐
Double Vision	☐	☐	☐
Blurred Vision	☐	☐	☐

Please list your past surgical history: ____

____

____

Is there anything else we should be aware of while treating you, which could affect your rehabilitation? ____________

____

____

MEDICATION INFORMATION

Please list your current medication information below: *(use back of page if more space is needed)*

MEDICATION	DOSAGE	FREQUENCY	METHOD OF ADMINISTRATION
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: _______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: __________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: _______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: __________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: _______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: __________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: _______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: __________________
		□ As Needed □ Once Daily □ Twice Daily □ Three Times Daily □ Other: _______________	□ Oral □ Sublingual □ Topical □ Subcutaneous Injection □ Other: __________________

PATIENT/GUARDIAN CONSENT

By signing below, you agree to the following:

I authorize release of information requested by my insurance plan for payment.
I understand that I am responsible for any balance due.
I agree to comply with the terms and conditions as outlined in the Patient Registration form.
I consent to physical therapy evaluation and treatment.
I understand that my care may be discontinued after 3 unexplained absences if I do not call within 24 hours of the scheduled treatment time to give notice of my absence or attempt to reschedule my appointment time.

Notice of Privacy Practices:

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Guardian: ____ **Date:** _____/______/________

Appointment reminders are available via e-mail. Would you like to receive reminders for future appointments?:

□ Yes. My email is ____. **□ No, thank you.**