PHYSICAL THERAPY ASSOCIATES

PATIENT HEALTH INFORMATION

DATE:

PATIENT INFORMATION

Name:	**Date of Birth:**
Primary Care Physician:	**Main reason for visit today:**
Last Visit With Physician:	**Onset:**

Surgeries:

In the past 3 months have you had or do you experience the following (Choose Yes or No)

Numbness or Tingling	
Shortness of Breath	
Dizziness	
Change in you balance (inc. falls)	
Fatigue or Weakness	
Double Vision or Loss of Vision	
Arm or Leg Swelling	
Recent Falls	
Sudden Weight Change	

Other medical issues:

Do you have a Pacemaker?	
Do you have any other electrical implants?	
Are you latex sensitive?	
Have you had testing for this problem?	
Are you currently pregnant?	
Do you feel unsafe at home?	
Do you or have you, in the past, smoked tobacco?	

Patient's Goals:

Patient's Signature / Initials: **Date:**

Therapist Signature / Initials: **Date:**