Cindi A. Prentiss, P.T., P.C.

Physical Therapy & Beyond

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PATIENT INFORMATION FORM

First Name_____ Last Name_____ Social Security No._____-_____-_____

Marital Status: (Circle One) Married/Single/Divorced/Widow/Widowed Spouse's/Partner Name_____

Birth Date _____Age_____ Sex: M/F R/L hand dominant_____. Height_____ Weight_____

Home Address_____ Home Phone_____

City/State/Zip_____ Cell Phone_____

Work Phone_____ E-mail_____ What is the best way to contact you? _____

Employer Name/ Work Address _____

Current Work Status: Full Time Part Time Retired Unemployed On Disability Restricted Work

Student Homemaker Not Working Due to Injury. Occupation: _____

Is this condition due to: ____Auto Accident ____Workers Comp Injury ____Slip and Fall ____Other

Have you received **physical therapy**, **occupational therapy**, **Chiropractor**, and/or **speech therapy** since January 1st of this calendar year? Yes/No If yes, which therapy did you have and what were you being treated for?

_____

Whom may we thank for referring you? _____

What is reason for today's visit?_____

_____

When is your next appointment with the doctor who is seeing you for this condition?_____

What are your *goals* you would like therapy to help you with? _____

_____

Please give a date this problem/ accident /injury started:_____

Have you been treated for this condition before? Yes/No **Have you received homecare services of any kind? Yes/No**

Dates and Descriptions of **Surgeries**: _____

_____

Allergies:_____

If you are pregnant/or previously pregnant : How many weeks: _____ Estimated Due date:_____

High Risk: Y/N Age/Premature contractions/incompetent cervix/episodic bleeding/nausea/multiple pregnancy

Schedule C-Section Y/N? if yes what is date of c-section:_____

How many pregnancies: _____ Natural/C-section. Episiotomy? Yes/No

# of living children_____ Ages of children: ____, ____, ___, ___

Have you experienced any loss of urine following previous childbirth? Yes/No Or as a child? Yes/No

If Applicable when was onset of Menopause?_____

Have you been on Hormone Replacement Therapy? Yes/No Dosage:_____Type:_____