MERRITT PHYSICAL THERAPY & REHABILITATION

PATIENT INFORMATION AND MEDICAL HISTORY

PH: 276-935-6496 FX: 276-935-5852

(PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE)

NAME: BIRTHDATE: SSN: AGE

MAILING ADDRESS: CITY: STATE: ZIP:

PHYSICAL ADDRESS: CITY: STATE: ZIP:

OCCUPATION: EMPLOYER:

MARITAL STATUS: M W S D SPOUSE / GUARDIANS NAME: DOB:

HOME PHONE# CELL PHONE# WORK PHONE:

EMERGENCY CONTACT: PHONE #

PRIMARY CARE PHYSICIAN: REFERRING PHYSICIAN:

DATE OF INJURY/ONSET: SURGERY:

BRIEFLY DESCRIBE YOUR INJURY/PROBLEM/CONDITION: IF MOTOR VEHICLE ACCIDENT WHAT STATE?______

◯ MRI ◯ CT ◯ X-RAYS ◯ OTHER_________________
◯ ULTRASOUND ◯ ULTRASOUND ___________________________

BIGGEST FUNCTIONAL LIMITATION (check one):

◯ SELF CARE / PERSONAL CARE ◯ CHANGING / MAINTAINING BODY POSITION

◯ WALKING & MOVING AROUND ◯ CARRYING / HANDLING / MOVING OBJECTS

◯ OTHER: ____

CURRENT PAIN / SYMPTOMS: ◯ NO PAIN ◯ LOCATION: ____________________

0 = NONE 5=MODERATE 10=SEVERE/EXTREME

AT WORST	1	2	3	4	5	6	7	8	9	10
CURRENT	1	2	3	4	5	6	7	8	9	10
AT BEST	1	2	3	4	5	6	7	8	9	10

WHAT MAKES IT WORSE?

◯ PROLONGED POSITIONS

◯ MOVEMENT

◯ OTHER: ______________________________

WHAT MAKES IT BETTER?

◯ MEDICATIONS ◯ ICE / HEAT

◯ OTHER: ______________________________

____

GENERAL MEDICAL HISTORY: HEIGHT:___________ WEIGHT:____________

HAVE YOU HAD HOME HEALTH SERVICES RECENTLY Yes No If yes, then Discharge date:____________________
HAVE YOU HAD ANY FALLS IN THE PAST YEAR? Yes No (how many) ______________________
DO YOU HAVE ANY METAL IMPLANTS? Yes No ______________________
DO YOU EXERCISE REGULARLY? Yes No HOW OFTEN? ______________________

(Mark all that apply)

◯ HIGH BLOOD PRESSURE	◯ CHF / COPD	◯ HEARING / VISION
◯ HEART ATTACK / MI	◯ ATRIAL FIBRILLATION	◯ ANXIETY / DEPRESSION
◯ DIABETES	◯ HEART MURMUR	◯ FIBROMYALGIA
◯ NEUROPATHY	◯ VASCULAR DISEASE	◯ PACEMAKER
◯ CVA / STROKE / TIA	◯ SMOKING	◯ ARTHRITIS / OSTEOPOROSIS
◯ SEIZURES	◯ SLEEP APNEA	◯ FREQUENT HEADACHES
◯ LUPUS	◯ BLOOD CLOTS / DVT	◯ GOUT
◯ KIDNEY PROBLEMS	◯ FAINTING / DIZZINESS	◯ CANCER

◯ FRACTURES: ______________________________

◯ SURGERIES: ______________________________

____

◯ ALLERGIES: ______________________________

◯ OTHER: ______________________________

◯ CURRENT MEDICATIONS: ______________________________

____

◯ BLOOD THINNERS

DO YOU HAVE AN ? ◯ ADVANCED DIRECTIVE / LIVING WILL ◯ DNR Order

PATIENT GOALS: "After Therapy is finished I would like to be able to..." ______________________________

____

____

PATIENT SIGNATURE: **X** ______________________________ DATE: ____________________

FOLLOWING QUESTIONS FOR PEDIATRIC PATIENTS ONLY:

1. Any complications during pregnancy, labor or delivery? ____

2. Any primary concerns at this time? ____

3. APGAR Score?____________________________

4. Any medical concerns or illness since birth?____

5. Does the patient have any siblings?____

6. If so, what are the ages of the siblings?____

7. What age did the patient meet the following milestones:
* Sitting with support?________________________
* Rolling? ____________________________________
* Sitting Independently?______________________
* Crawling?___________________________________
* Walking? ___________________________________
* First Words: _______________________________
* Babbling? __________________________________
* Combining Words? _________________________

8. List any doctors that your child has been treated by:____

9. Any medications? List: ____
____
____

10. Communication:

When/Where was their most recent hearing test? ____

When/Where was their most recent vision test? ____

Did your child have difficulties with feeding after birth? Breast: Yes No Bottle: Yes No
If yes, please explain: ____
____

Does your child currently have any swallowing difficulties/excessive coughing or choking when eating or drinking: Yes No
If yes, please explain: ____
____

PARENT/GUARDIAN SIGNATURE: **X**__________________________________ **DATE:** __________________

Pediatric Pick-Up Authorization

I. *Personal Information (please print)* Today's Date: _____/_____/_____

Child's Name: ____ Age: _______________

Parent/Guardian Names: ____

Home Phone: _______________________ Work Phone(s): ___________________________

Cell Phone(s): ____

II. Authorized Pick Up

*Please list any individual who is authorized to pick up your child, including yourself. Each authorized person must be at least 16 years of age. The above-named child will **NOT** be permitted to leave the clinic with anyone who is not listed below. Authorized individual must pick up the child in person and may be requested to show identification to clinic staff. Children will **NOT** be released to persons who fail to provide acceptable identification upon request.*

I authorize the following responsible persons to pick up my child from the therapy clinic once my child has completed his/her therapy session.

Authorized Person	***Phone Number***	***Relationship to Child***

Please note that children must be picked up by designated times. If an authorized adult is unable to be reached by phone, clinic staff will contact the local police department as a last resort to take your child home.

III. Authorized Dismissal

*My child is **at least 16 years** of age and will be responsible for his/her own transportation to and from the program. My child may sign himself/herself out at the end of the program activities.*

Signature of Parent or Guardian: ____

Parent or Guardian Name: ____

****Please note that only the enrolling parent will be permitted to complete this form.***