WAVERLY HEALTH CENTER

Patient Sticker

TAYLOR PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY
PATIENT MEDICAL HISTORY

☐ New Patient ☐ Established Patient

Name _____ Birth Date _____ Age _____

Where Employed _____

Home Phone _____ Cell Phone _____

May we contact you by email? ☐ Yes ☐ No Email Address _____

Have you been treated by a physical, occupational or speech therapist, or chiropractor at any facility within this past calendar year?
☐ Yes ☐ No If so, number of visits _____

Are you currently being seen by a Home Health Agency? ☐ Yes ☐ No Name of Agency_____

Brief description of injury or illness _____
_____

Date symptoms started _____

Is your injury: Work related? ☐ Yes ☐ No Motor vehicle accident? ☐ Yes ☐ No

What are your goals for therapy? _____
_____

Do you have or have you had any of the following?

☐ Heart problems
☐ Pacemaker
☐ High/low blood pressure
☐ Circulatory problems
☐ COPD/emphysema
☐ Asthma
☐ Shortness of breath
☐ Chronic ulcer
☐ Anemia
☐ History of smoking
☐ Diabetes
☐ Kidney disease
☐ Cancer
☐ Hepatitis
☐ Tuberculosis
☐ Rheumatic fever
☐ Multiple sclerosis
☐ Blood clots
☐ Back pain/sciatica
☐ Osteoporosis
☐ Artificial joints/implants
☐ Seizures
☐ Dizziness/vertigo
☐ Depression/mental illness
☐ Stroke
☐ Hearing/visual difficulties
☐ Rheumatic arthritis
☐ Other arthritic conditions
☐ Currently or possibly pregnant
☐ Dementia/memory
☐ Hx of TBI/concussion/head injury
☐ Word finding difficulty
☐ Swallowing challenges
☐ GERD/Acid reflux

Have you fallen 2 or more times within the last year? ☐ Yes ☐ No

List any other medical information or special tests you've completed that you believe would be beneficial for us to be aware of:
_____
_____

Current Medications _____
_____

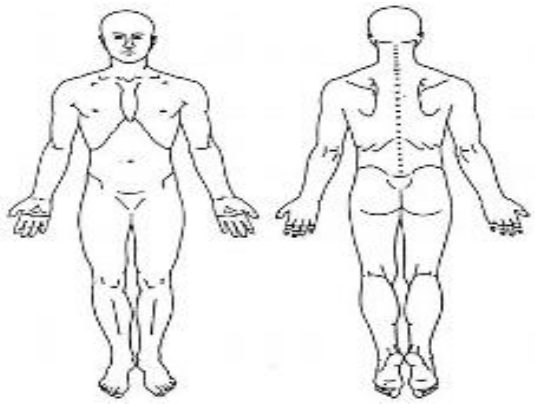
Weight _____ Height _____

(PLEASE FILL OUT BACK PAGE)

Patient Sticker

PATIENT MEDICAL HISTORY

Mark on the diagram below where you currently are experiencing symptoms:



Mark below the intensity of your symptoms.

Please circle the appropriate number (0 = no symptoms; 10 = worst possible symptoms)

Currently:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

How restricted are your normal activities?

(0 = No Limitations; 10 = Totally Disabled)

0 1 2 3 4 5 6 7 8 9 10

Work capabilities since your injury:

☐ No Work Limitations
☐ Some Work Limitations
☐ Unable to Work
☐ N/A (Child, Student, Retiree, Disabled)

How often do you have these symptoms? *(Please check one below)*

☐ (24 hours/day) ☐ Frequently (12-23 hours/day) ☐ Occasionally (6-12 hours/day) ☐ Not Frequently (0-6 hours/day)

Please list other treatment you have received for this condition_____
_____

Who was your referral source for physical therapy in general: ☐ Physician Name _____ ☐ Self-Referral

How did you hear about Taylor Physical Therapy specifically? *Check* the appropriate category and check the specific subcategory under each category.

☐ Returning Patient:
- ☐ Newsletter
- ☐ Postcard

☐ Advertising:
- ☐ Social Media
- ☐ Radio
- ☐ Newspaper
- ☐ Commercial
- ☐ Flyer

☐ Word of Mouth:
- ☐ Friends & Family
- ☐ Community event
- ☐ Friends with Therapist

INFORMED CONSENT

I hereby authorize treatment to be administered after evaluation according to the therapist's discretion. This may include, but not limited to, spinal or joint traction, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I understand that the necessary procedures to be provided will be explained along with the risks and benefits.

Patient's Signature _____ Date _____