



Gaston Rehab Associates, Inc.

Physical Therapy

Name: _____
(Last) (First) (M.I.)

Date Of Birth: _____
(MM/DD/YYYY)

Home Phone: _____

Social Security #: _____

Street _____

Address: _____

(City) (State) (Zip)

Type Of Insurance:

- Insurer: _____
- Worker's Comp: _____
- Medicare
- Medicaid
- Self Pay
- Other: _____

Emergency Contact Information:

Name: _____

Relation: _____

Phone Number: _____

Address: _____

Social History:

A. With Whom Do You Live?

- Alone Spouse Only
- Spouse and others Child (not spouse)
- Other Relatives (not spouse or children)
- Group Setting
- Personal Care Attendant
- Other: _____

B. Employment:

Are You Currently Employed? _____

If Yes:

Occupation: _____

Hours Per Week At Job: _____

If No:

- Retired Student Disabled

Living Environment:

A: Where Do You Live?

- Private Home Apartment
- Rented Room Hospice
- Assisted Living/Group Home
- Long Term Care (Nursing Home)
- Homeless (with or without shelter)
- Other: _____

B: Does Your Home Have?

- Stairs: Railings: No Yes 1 2
Number of Steps: _____
- Ramps Elevator
- Uneven Terrain
- Assistive Devices (grab bars, etc.): _____
- _____
- Other: _____

C: Do You Use:

- Rolling Walker Walker
- Hemi-Walker Cane
- Manual Wheelchair
- Electric Wheelchair
- Hearing Aides Glasses
- Other: _____

D: General Health Status:

1. Please Rate Your Health:

- Excellent Good
- Fair Poor

2. Have You Had Any Major Life Changes During The Past Year?

(eg: new baby, job change, death of a family member)

- Yes No

3. Do You Smoke? No

Yes, Packs Per Day: _____

4. Do You Regularly Exercise? No

Yes, Times A Week: _____

Do you have an E-Mail Address?

- Yes No



Patient History Page 2

Name: _____

Medical/Surgical History:

(Please Check All That Apply)

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Vision Impaired | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Parkinson Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Joint Replacement: _____ | |
| <input type="checkbox"/> Major Surgery: _____ | |
| <input type="checkbox"/> Other: _____ | |

Current Condition/Chief Complaint(s):

A. Describe the problem(s) for which you seek physical therapy: _____

B. Approx. When Did This Begin?: _____

C. How Did This Happen? _____

D. Have You Ever Had This Problem Before? No Yes
If Yes, What Did You Do For It?: _____

Did It Get Better? No Yes

E. How Are You Taking Care Of The Problem(s) Now? _____

F. What Makes The Problem:

Better: _____

Worse: _____

G. What Are Your Goals For Physical Therapy? _____

H. Have You Seen Anyone Else About Your Problem(s)? _____

I. Have You Had Any Diagnostic Testing For Your Problem(s)? _____

Medications:

A. To The Best Of Your Ability, Please List All Medicines That You Are Currently Taking: _____

B. Have You Ever Received Any Injections For Your Problem? No Yes
If Yes, When? _____

I have completed the above to the best of my knowledge and belief, it is true, correct, and complete.

(Signature)

(Date)

If under 18, please have parent or guardian sign.