CITY PHYSICAL THERAPY, PC

Medical History Form

Name: _____ **Referring Doctor:** _____ **Date:** _____

Current Injury/Condition: _____

Please check any of the following who you have seen related to this injury/condition:

__ Primary Care Physician __ Orthopedist __ Acupuncturist __Chiropractor

__ Physiatrist (PMR) __ Osteopath __Massage Therapist __Other:_____

Did you receive previous Physical Therapy for this Condition? __Yes __No.
Did you have surgery Related to this injury/Condition? __Yes __No. If yes, Type/Date: _____
Was this injury/condition the result of a work related or motor vehicle accident? __Yes __No

General Medical History. Please check any conditions you currently have, or have been diagnosed with in the past.

__Heart Problems/Surgery. Please specify: _____

__High Blood Pressure. If so, controlled with Medications: __Yes __No

__Diabetes. If so, controlled with: __Medications __Diet __Exercise __Uncontrolled

__Cancer. If so, please specify type and date: _____

__Stroke/TIA. If so, please specify date: _____

__Infectious Disease. If so, please specify: _____

__Do you have a pacemaker: __Yes __No

__Allergies. If so, please specify: _____

__Joint Replacement. If so, please specify type and date: _____

__Kidney Problems __Liver Problems __Chemical Dependency (i.e., alcoholism)

__Thyroid Problems __Arthritis (osteoarthritis) __Rheumatoid Arthritis

__Depression __Hernia __Osteoporosis/Osteopenia

__Asthma __Vision Difficulties __Hearing Difficulties

__High Cholesterol __Epilepsy/Seizure Disorder

Other surgeries: _____.

Other medical conditions: _____.

Are you Pregnant? __Yes __No __N/A __ Are you trying to become pregnant? __Yes __No __N/A

Do you smoke? __Yes __No. If yes, how many packs/day? _____

Do your drink alcohol? __Yes __No. If yes, how many drinks/week? _____

Medication. Please List Type and Dosage of any Medications/Vitamins/Herbs/Supplements you take regularly.

Type _____ Dosage_____ Type _____ Dosage_____

Type _____ Dosage_____ Type _____ Dosage_____

Type _____ Dosage_____ Type _____ Dosage_____

Activities:

Work: Are you currently working? __Yes __No. If yes, what type of work do you do? _____
Leisure: Please List any Sports/Recreational/Leisure/Fitness Activities you participate in:

Activity	Frequency/Week
_____	_____
_____	_____
_____	_____

Patient Signature: _____ **Date:** _____

Please provide us with an Emergency Contact:

Name: _____ Relation: _____

Phone Number(s): _____

Attendance Policy

We at City Physical Therapy, P.C. strive to provide the highest level of patient care. In order to provide hands-on time with each patient we reserve time slots for each appointment.

Consistent attendance is the key to recovery. Physicians generally prescribe 2-3 P.T. visits per week for the best results. Our attendance policy is made to ensure patients receive quality care and the optimal benefits from treatment.

1. Please be ready to receive treatment at your scheduled time. If you are late for your appointment, we will need to shorten your session or reschedule your appointment all together.

2. We ask that patients give us a minimum of 24hours notice when canceling an appointment. We will work with you to reschedule your appointment in the same business week.

3. If you are unable to reschedule in the same business week, and fail to give us 24 hours notice when canceling, we will charge you a $50 late cancel fee, payable at your next appointment.

4. If you have 2 late-cancels or no-shows, we reserve the right to remove any future appointments from our schedule.

5. We do understand that emergencies occasionally arise and will take such situations into consideration.

I agree to the terms above.

Patient Signature: _____ **Date:** _____