PERSONAL IDENTIFICATION INFORMATION

Odessa·Physical·Therapy

Name:	Home Phone:		Cell Phone:
Street Address:	Mailing Address:		
City, State, ZIP:	Birth Date:	Age:	Sex:
Social Security Number:	Occupation:		
Employer:	Employer Phone:		
If married, Spouse's Name:	Spouse's Cell Phone:		
Spouse's Employer:	Spouse's Employer Phone:		
If minor, Guardian's Name:	Guardian's Cell Phone:		
Guardian's Employer:	Guardian's Employer Phone:		
Referring Physician:	Referring Physician's Phone:		
Primary Care Physician:	Primary Care Physician's Phone:		
Emergency Contact:	Emergency Contact Phone:		

Did this injury happen on the job?	☐ Yes	☐ No
Are you claiming Workers' Compensation?	☐ Yes	☐ No
Have you notified your employer?	☐ Yes	☐ No

WORKERS' COMP INSURANCE CARRIER:		
Adjuster:	Claim Number:	
Employer (at time of injury):	Employer Phone:	
Employer Address:	Nurse Case Manager (If applicable):	
PRIMARY INSURANCE CARRIER:		
Insured's Name:	Employer:	
Insured's SSN:	D.O.B.:	Relationship:
SECONDARY INSURANCE CARRIER:		
Insured's Name:	Employer:	
Insured's SSN:	D.O.B.:	Relationship:

PAST MEDICAL HISTORY FORM

Odessa · Physical · Therapy

PATIENT NAME:

BLOOD PRESSURE	YES	NO
Hypertension (High Blood Pressure)	☐	☐
Low Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Atherosclerotic Disease	☐	D
Heart Murmur	☐	D
Myocardial Infarction (Heart Attack)	☐	☐
Rheumatic Heart Disease	☐	D
MUSCLE CONDITION	**YES**	**NO**
Back/ Neck Problems	☐	☐
Carpal Tunnel Left Right	☐	☐
Limited Limb Movement	☐	☐
Tennis Elbow Left Right	☐	☐
LUNGS	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐
DO YOU HAVE ANY IMPLANTABLE DEVICE?		
Pacemaker	☐	☐
Pain Stimulator	☐	☐

JOINT CONDITIONS	YES	NO
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Rheumatoid Arthritis	☐	☐
OTHER CONDITIONS	**YES**	**NO**
Diabetes	☐	☐
Epilepsy	☐	☐
Fibromyalgia	☐	☐
Hearing Loss	☐	☐
Mental Heath	☐	☐
Multiple Sclerosis	☐	☐
Muscular Dystrophy	☐	☐
Polio	☐	☐
Poor Eyesight	☐	☐
Reynaud's Disease	☐	☐
Seizure Disorder/Medication	☐	☐

Other devices:

EXERCISE		WORK ACTIVITY		STRESS LEVEL		HABITS		
☐	None	☐	Sitting	☐	Low	☐	Alcohol	Drinks a week?
☐	1-2x Week	☐	Standing	☐	Medium	☐	Coffee/Soda	Cups a week?
☐	3-4x Week	☐	Light Labor	☐	High	☐	Smoking	Packs per day?
☐	S+x Week	☐	Heavy Labor					How many years?

What type of exercise do you perform?

What things cause stress in your life?