

Burhani Physical Therapy & Rehabilitation

Patient Information

Patient Name:	Home Phone:	Work Phone:
Street Address:	Cell Phone:	
PO Box:	Date of Birth:	
City, State, Zip:	Social Security #	
E-Mail Address:		
Sex: Male Female	Marital Status:	
Employer:	Occupation:	
Address:		
Referring Physician:	PCP:	

Emergency Contact Information

Name:	Relationship:
Contact Number:	
Cell Phone:	

Insurance Information

Primary Insurance:	Secondary Insurance
Address:	Address:
City, State, Zip:	City, State Zip:
Phone#:	Phone#:
Group/Claim#:	Group/Claim#:
Subscriber ID#:	Subscriber ID#:

Current Medications

If none circle NONE			

Known Allergies _____

Adverse Reactions to Medications _____

What is the problem that brings you to therapy?

Is your condition due to Auto Accident Fall Work Injury Other

Date of Onset: _____

Prior therapy for this condition: Yes No

If this is workman's comp injury, where were you working when this injury occurred?

Medical History

	YES	NO		YES	NO	Comments
Heart Attack			Diabetes			
Heart Disease			Cancer			
Pacemaker			Kidney/Urinary			
High Blood Pressure			Stomach/Gastrointestinal			
Low Blood Pressure			Infectious Diseases			
Circulation/Vascular/Bleeding			Stroke			
Tuberculosis			Epilepsy/Seizures			
COPD			Head Injury			
Dizziness			Veicular Accidents			
Arthritis			Psychiatric History			
Osteoporosis			Swallowing difficulties			
Joint Replacement			Pregnancy			
Musculoskeletal			Skin Cancer			
Headaches			Skin Disease			
HIV Positive						

Surgical History

If none circle NONE			

Do you have difficulty with:

	YES	NO		YES	NO	Comments
Bladder Control			Fatigue			
Bowel Control			Blurry Vision			
Sleeping			Double Vision			
Depression			Swelling			
Chest Pain			Breathing			
Nausea/Vomiting						
Weight Gain/Loss						

Do you smoke? Y/N

Do you drink alcohol? Y/N

What are your goals for treatment? _____

Is there anything we need to know that is not covered on this form? YES

Please explain _____

Name of person completing form _____

Date _____

Therapist's Signature _____

Date _____