ProFysio Physical Therapy
1212 Route 34 Suite 24-25 Aberdeen, NJ
P: 732.970.7882 • F: 732.970.7883

Please mark the reason you chose ProFysio for your physical therapy:

___ Physician referral ___ Close to home ___ Family ___________
___ Insurance Plan ___ Close to work ___ Friend ___________
___ Phone book ___ Internet ___________ ___ Other ___________

PATIENT INFORMATION

Date: __________ Last Name: ______________ First Name: ______________ M. I. _____
Birth Date: __________ Age: _____ Name you would like us to call you: ______________
Home phone: ____________ Cell phone: ______________ Work phone: ____________
Address: ____
City: ______________________State:__________Zip:______________
Social Security Number ______________
E-mail address: ____
Preferred method of contact: ___ Home ___ Cell ___ Work
Marital status: ___ Single ___ Married ___ Divorced ___Widowed ___ Other
Are you employed? ___ Yes (______hours/week) ___ No ___ Retired
Job title/type of work: ________________________________
Are you disabled? ___ Yes ___ No Reason: ______________________

Emergency contact: ______________ Relationship to patient: ______________
Home #: ______________ Cell #: ______________ Work #: ______________

HEALTH HISTORY

Have you ever had an allergic reaction to: ___ Lotion; ___ Perfume; ___ Gel; ___ Latex; ___ Adhesive; ___ Tape
Other allergies: ____
Height:______________________ Weight:______________________
Surgeries: ____
____
Diagnostic tests (date of test) : X-rays: (__________) MRI: (__________) CTScan: (__________)
Other: ____

Have you ever been diagnosed as having any of the following conditions?

___ Arthritis
___ Cancer (type ______________)
___ High blood pressure
___ Asthma
___ Chemical dependency (i.e. alcoholism)
___ Diabetes
___ Rheumatoid Arthritis
___ Depression
___ Tuberculosis
___ Kidney Disease
___ Epilepsy/Seizures
___ Osteopenia/Osteoporosis
___ Pacemaker/Electrical implant
___ Hard of Hearing
___ Heart Problems ______________
___ Circulation problems
___ Emphysema/Bronchitis
___ Thyroid problems
___ Multiple Sclerosis
___ Fibromyalgia
___ Hepatitis (Type ________)
___ Stroke
___ Anemia
___ Incontinence
___ HIV/AIDS
___ Other ______________
___ Could you currently be pregnant?
___ Vision difficulties ______________

Have you recently noted:

___ Unexplained weight loss/gain
___ Dizziness/lightheadedness
___ Weakness
___ Numbness or tingling
___ Headaches
___ Nausea/vomiting
___ Fatigue
___ Fever/chills/sweats
___ Bowel or bladder leakage
___ Other ______________

PATIENT'S NAME: ____________________________________

Current Medications, dosages, frequency (please list):
____
____
____
____

Do you exercise beyond normal daily activities and chores? ____ Yes ____ No
How many days per week do you exercise? __________ For how long? ______________________
Describe the exercise(s): ____
____

Are you currently performing your normal exercise routine? ____ Yes ____ No

MEDICAL/REHABILITATIVE SERVICES

Please list any other healthcare practitioners from whom you are currently receiving services:
____
____
____
____

Have you been discharged from a rehabilitation facility, skilled nursing facility, or home health recently? ____ Yes ____No

Have you had any physical therapy services for the same condition elsewhere? ____ Yes ____ No
If you answered yes, please list the clinic, year, and how many visits you received:
Clinic: ______________________ Year: __________ Visits: ____________

REASON FOR VISIT

Briefly explain what happened: ____
____
____

What is your main complaint? ____
____
____

How is your injury limiting your function? ______________________________________
____
____

Circle one answer for each of the following:

Are your symptoms:	Getting worse	Staying the same	Improving	
My symptoms are worse in the:	Morning	Afternoon	Evening	Night
My symptoms are best in the:	Morning	Afternoon	Evening	Night
Sleeping at night is:	Normal without meds	Interrupted	Difficulty falling asleep	

Rate your pain on a 0-10 scale (0=no pain; 10=emergency room pain): Now: _______ Best: _______ Worst: _______

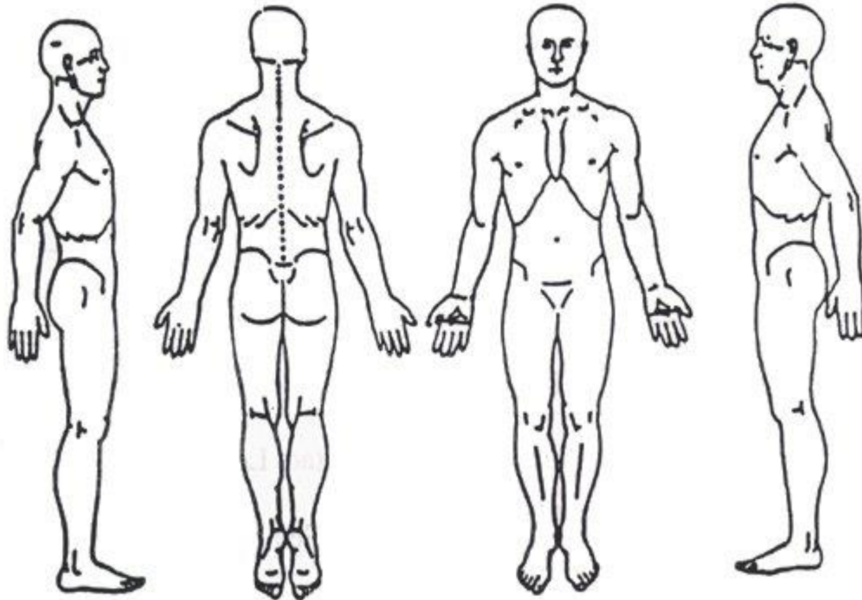
PATIENT'S NAME:____

BODY DIAGRAM

Please describe in your own words the type of pain you are experiencing (i.e. sharp, stabbing, dull, aching, throbbing, etc.) ____
____
____

Is your pain: _____ Intermittent ______ Constant
_____ Activity dependent; worse with ____
better with ____

Please indicate on the body diagrams below where you are experiencing your symptoms: experiencing pain, numbness, tingling, etc.



Is there anything else you feel we should know? ____
____

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PATIENT'S NAME:______________________________________

Insurance

Primary Insurance
Insurance Company______________________________

Policy# ____

Group#/Claim#__________________________________
Phone ____
Claims Address _________________________________
City ____________________ State ______ Zip ______

Insured Name ___________________________________
Relationship to Patient __________________________
Employer _______________________________________
Soc. Sec. __________________ Birthdate __________

Secondary Insurance
Insurance Company ______________________________

Policy# ____

Group # ____
Phone ____
Claims Address __________________________________
City ____________________ State _____ Zip _____

Insured Name ___________________________________
Relationship to Patient ___________________________
Employer ____
Soc Sec. ________________ Birthdate ___________

Workers Compensation
Contact/Adjuster_______________________________

Claim Number # ________________________________

Phone ____
Claims Address _________________________________
City ____________________ State ______ Zip ______

SIGNATURE

I certify that the above information is correct to the best of my knowledge. I will not hold any therapist or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Name (printed): ______________________________

Patient Signature: ___________________________________ **Date:** __________________