ELEVATE
PHYSICAL THERAPY

Return Patient History

Name:_____ **Height:**_____ **Weight:**_____

1) Has any of the following information changed since your last visit?

Address_____ Phone # _____ Insurance_____

If so, please provide us with the new information:

_____

_____

2) Have you had any physical therapy or home health since January of the current year? Y N Date: _____ Location: _____

3) Is this related to an automobile or WCOMP accident? Y N

If so, please provide date of injury and billing information:

_____

_____

4) Would you like to receive appointment reminders? Y N

How would you like to receive your reminders?

Email: _____ Phone Call: _____

Text Message: _____

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Current Condition/Chief Complaint: Date of Onset: _____

Describe the problems for which you seek physical therapy:

_____

_____

Pain Level: Please rate your pain on a scale of 0-10. 0 being no pain, 10 being severe pain.

Current Pain: _____ Best Pain: _____ Worst Pain: _____

What are your goals in physical therapy?

_____

_____