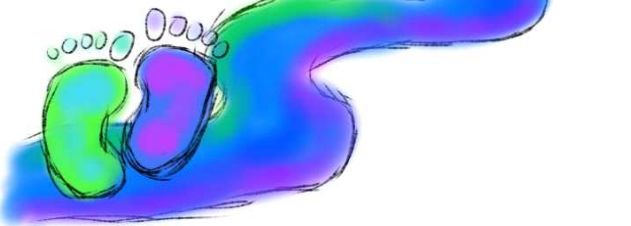


Pro Step Therapy

Olivia Taylor, MPT, DPT



7011 Gum Branch Road
Richlands, NC 28574

Phone: (910) 430-2201

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Fax: (888) 653-7243

Email: prosteptherapy@gmail.com

Patient Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

_____ Current Age: _____

Circle the Best Phone # to Contact Home: _____ Height: _____

Cell: _____ Other: _____ Weight: _____

Text for Appointment Reminders: Yes No Email: _____

Parent(s)/Guardian(s) OR Emergency Contact Name(s): _____

Emergency Contact Phone Number(s): _____

Insurance Co: _____ Policy #: _____

Insurance Group #: _____ Policy Holder Name: _____ DOB: _____

Primary Medical Facility: _____ Physician Name: _____

Office Location: _____ Referring Provider (if diff): _____

Reason For Referral and any other concerns you may have: _____

Past Medical Info/History: _____

Please list any Medical Diagnosis: _____

Please list any Allergies: _____

Please list any current medications you are taking:

Drug	Dosage	Frequency	Route (oral, topical, injection etc)	Reason taking
1.				
2.				
3.				
4.				
5.				

Patient Name: _____ DOB _____

Please circle yes/no to any of the following that apply to currently or in the past:

Allergies	Yes	No	Diabetes	Yes	No	MRSA	Yes	No
Anemia	Yes	No	Dizzy Spells	Yes	No	Multiple Sclerosis	Yes	No
Anxiety	Yes	No	Emphysema/Bronchitis	Yes	No	Muscular Disease	Yes	No
Arthritis	Yes	No	Fibromyalgia	Yes	No	Osteopenia	Yes	No
Asthma	Yes	No	Fractures	Yes	No	Rheumatoid Arthritis	Yes	No
Autoimmune Disorder	Yes	No	Headaches	Yes	No	Seizures	Yes	No
Cancer	Yes	No	Hearing Impairment	Yes	No	Speech Problems	Yes	No
Cardiac Conditions	Yes	No	Hepatitis	Yes	No	Strokes	Yes	No
Cardiac Pacemaker	Yes	No	High/low blood Pressure	Yes	No	Thyroid Disease	Yes	No
CMV (cytomegalovirus)	Yes	No	HIV/AIDS	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Incontinence	Yes	No	Vision Problems	Yes	No
Depression	Yes	No	Kidney Problems	Yes	No	OTHER	Yes	No

Please explain any circled yes: _____

FOR PEDIATRIC OR ADOLESCENT PATIENTS, PLEASE COMPLETE THE FOLLOWING:

Were there any complications during your pregnancy or during your child's birth? _____

Was your child born prematurely? (If yes how many weeks early) _____

Please indicate if your child is able to do the following. If yes, list the age this occurred (or approximate if unsure):

Sit Unsupported	Yes	No	Age:	Catch a Ball	Yes	No	Age:
Crawl	Yes	No	Age:	Write their Name	Yes	No	Age:
Walk	Yes	No	Age:	Potty Trained?	Yes	No	Age:
Talk	Yes	No	Age:				

Name of the person completing this form if other than patient: _____

Relationship to patient: _____ Signature: _____