IMPERIAL PHYSICAL THERAPY

1030 South Glendale Ave Unite 506
Glendale CA 91205
Tel: 818-484-7941 Fax: 818-484-7943

Patient Information Form

Name:_____

First Middle Last

Address:_____

City:_____**State**:_____**Zip Code**:_____**Date of Birth**:_____

Home Phone:_____ **Cell Phone**:_____ **Social Security #:**_____

Email:_____

Driver's License:_____ **Age**:_____ **Sex** (please circle): Male Female

Height:_____ **Weight:**_____

Marital Status (please circle): Married Single Divorced Widowed Other

Subscriber Name:_____ Date of Birth:_____

Consent to Procedure: I hereby consent to and authorize Imperial Physical Therapy (IPT) to perform therapeutic services in accordance with the general and special instructions of my treating physician or the therapist supervising the services. I understand I am financially responsible for my account with Imperial PT, regardless of any Insurance benefits & that cancellations have a serious impact on the clinic, I am aware of any fees charged for not giving 24 hr notice of cancellation. This form is valid for care provided by Imperial PT for a 12 month period beginning the date of this document.

_____

Patient Signature **Date:**

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your Protected Health Information (PHI). You can request a copy of this form

Physical Therapy History

Name: Today Date:

Date of Birth: Referring Doctor:

CHIEF COMPLAINT

Why are you seeing the therapist today? ( ) right ( )left _____
When did this problem begin? _____
How did this problem begin? _____
Have you had Xrays or MRI?_____
Current problem is the result of (check all that apply)__Car Accident ___Work Injury____Other Injury
Date of injury: _____

PAST MEDICAL HISTORY

Heart Disease	Yes	No	Arthritis	Yes	No
High Blood Pressure	Yes	No	Gout	Yes	No
Diabetes	Yes	No	Tuberculosis	Yes	No
Emphysema	Yes	No	Ulcers	Yes	No
Asthma	Yes	No	Seizures	Yes	No
AIDS	Yes	No	Thyroid disorders	Yes	No
Cancer	Yes	No	Bleeding disorders	Yes	No

Hepatitis A B C (please explain any "yes" answers)

PAST SURGICAL HISTORY

Surgeries/Hospitalizations	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had physical therapy? ____Yes, _____No
If yes, did you have any problems with physical therapy? ____Yes, ____ No
If yes, please describe _____

MEDICATIONS

Medication	Dose	Reason for Medication	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies_____