

NORTH COUNTY WATER & SPORTS THERAPY CENTER

Frogs Club One/Carmel Mountain Ranch•12171 World Trade Drive•San Diego, CA 92128• (858) 674-4480

Patient Information Form

Name: (last) _____ (first) _____ (MI) _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home Phone: _____

Employer (Name): _____ Work Phone: _____ (ext): _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Emergency Contact: _____ Day Phone: _____ Evening Phone: _____

Referring Physician: _____ Phone: _____

Address: _____ City: _____

Family Physician: _____ Phone: _____

Whom may we thank for referring you to us? _____

Have you ever received physical therapy before? Yes No Where? _____

When? _____ For what diagnosis? _____

General Medical History

| | | | |
|---|--------|--|--------|
| Do you now have or have you had any of the following? | | Are you pregnant? Yes/No | |
| High blood pressure | Yes/No | Do you smoke? | Yes/No |
| Arthritis | Yes/No | Are you taking any medications? | Yes/No |
| Allergies | Yes/No | please list: _____ | _____ |
| Ulcers/stomach problems | Yes/No | Have you had nay surgeries? | _____ |
| History of seizures | Yes/No | please list (include type and date of surgery) | _____ |
| Tuberculosis | Yes/No | _____ | _____ |
| Asthma/lung problems | Yes/No | Comments: _____ | _____ |
| Shortness of breath | Yes/No | _____ | _____ |
| Diabetes, Hypoglycemia | Yes/No | What goals do you wish to achieve in physical therapy? | _____ |
| Neurological problems | Yes/No | _____ | _____ |
| Emotional/psychological problems | Yes/No | _____ | _____ |
| Heart Disease/problems | Yes/No | | |
| Chest pain | Yes/No | | |
| Circulation problems | Yes/No | | |
| Dizziness, nausea | Yes/No | | |
| Skin problems | Yes/No | | |
| Kidney problems | Yes/No | | |
| Liver problems | Yes/No | | |
| Thyroid problems | Yes/No | | |
| Cancer | Yes/No | | |
| Repeated infections | Yes/No | | |
| Weight loss or gain | Yes/No | | |
| Osteoporosis | Yes/No | | |
| Vision or hearing difficulties | Yes/No | | |
| Sensitivity to heat or cold | Yes/No | | |
| Any orthopedic problems | Yes/No | | |
| Broken bones/fractures | Yes/No | | |

Patient Signature: _____ Date Completed: _____