Northville Physical Rehabilitation

Please provide the necessary information in the form below. All fields highlighted in red are required. You may submit the form to krhnpr@gmail.com by using the submit button or print the form and bring it to the office for your first visit.

Patient Information Profile

□ New Patient □ Re-Start □ New Diagnosis

Treating Therapist:		Date/Time of 1st Appt.	
Patient #	Patient Name (Last, First, Middle)		
Address City/State/Zip			Email Address
Home Phone	Work/Cell Phone		Social Security #
Home Health Care ☐Yes ☐No	DOB	Sex ☐M ☐F	Referring Physician
Prescription Date/ Frequency/Duration		Injured Body Part/Diagnosis	
Emergency Contact (Name)		Emergency Contact Home Phone	Emergency Contact Work/Cell Phone
Emergency Contact Relationship To Patient		Patients Place of employment	
Patients Spouse/Parents Name		Patients Spouse/Parents DOB	

Injury Information

Is condition surgery related? □ Yes □ No	Date of surgery	Surgical procedure
Is condition accident related? □ Yes □ No	Was an automobile involved? □ Yes □ No	Date of accident
Were you injured on the job? □ Yes □ No	Date of injury	Name City/State/Zip of employer at time of accident
Is litigation involved? □ Yes □ No	Name of attorney/adjuster	

Insurance Information

Primary insurance	Claims mailing address City/State/Zip		
Subscriber Name	Date of birth	Sex ☐ M ☐ F	Relationship to patient
# (including alpha prefix)	Group #		Claim #
Secondary insurance	Claims mailing address City/State/Zip		
Subscriber Name	Date of birth	Sex ☐ M ☐ F	Relationship to patient
ID card # (including alpha prefix)	Group #		Claim #

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE.

PATIENT'S SIGNATURE:_____ DATE:_____

Northville Physical Rehabilitation

MEDICAL HISTORY FORM

Patient Name: _____

What body part are you here for? _____

When did your condition start? Give specific date of injury or onset: _____

Have you had previous physical therapy for this condition? Yes

Did you have surgery? Yes When? Give Date: _____

What surgery was done? _____

Did you have any of the following tests?

☐ X-Ray ☐ MRI ☐ CT ☐ EMG ☐ Other: _____

When is your next Doctor's appointment? Give Date: _____

Are you currently experiencing or have you experienced any of the following? (Check if Yes)

Diabetes ☐
High Blood Pressure ☐
Heart Disease ☐
Heart Attack ☐
Pacemaker ☐
Heart Murmur/Arrhythmia ☐
Stroke ☐
Shortness of Breath ☐
Asthma ☐
Cancer ☐
Thyroid Problems ☐
Kidney Problems ☐
Infectious Disease/HIV/Hepatitis ☐
Pregnant/IUD ☐

Hernia ☐
Nervous Disorders/Depression ☐
Seizure ☐
Allergies/Skin ☐
Headaches/Dizziness ☐
Metal Implants ☐
Recent Fatigue/Weakness ☐
Recent Fever ☐
Recent Nausea/Vomiting ☐
Recent Chills/Sweats ☐
Recent Weight Gain or Loss ☐
Injured in a Motor Vehicle Accident ☐
Any Previous Injury ☐
Previous Surgery ☐

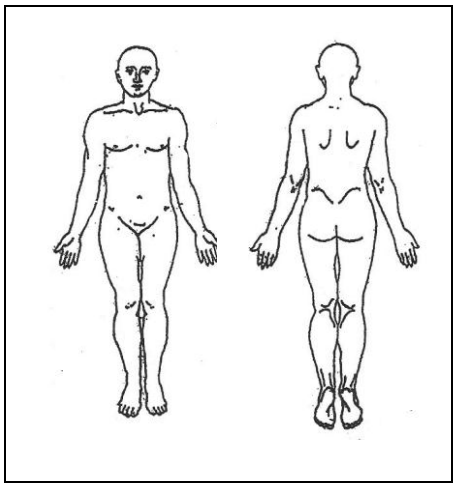
If YES on any of the above, please give details and approximate dates: _____

Are you currently taking any MEDICATIONS? Yes

Please List: _____

Do you have PAIN? If so, DRAW on the BODY CHART where you pain is located →

Yes



What does your pain feel like? (Check all that apply.)

☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness ☐ Other: _____

Does pain radiate to arms and/or legs? Yes

Rate your pain on a 0-10 scale (0=None, 10=Severe)

0

Does your pain awaken you at night? Yes

If so, how many times each night? _____

What makes the pain WORSE? (Check all that apply.)

☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Other: _____

What EASES the pain? (Check all that apply.)

☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Other: _____

Functional Activities – Can you drive? Yes Can you climb stairs? Yes Are you able to provide self-care? Yes

Leisure Activities: Please List: _____

Is there anything else you want us to know about your condition? _____