

FORTÉ REHABILITATION & WELLNESS CENTER

PATIENT INFORMATION RECORD

PATIENT NAME		MARITAL STATUS S M D W	SEX M F
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PATIENT ADDRESS	CITY	STATE	ZIP CODE
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HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER
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E-MAIL (WE SEND APPOINTMENT REMINDERS BY E-MAIL)	PATIENT SOCIAL SECURITY #	PATIENT DOB
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NAME OF POLICYHOLDER	POLICYHOLDER SOCIAL SECURITY #	POLICYHOLDER DOB
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REFERRING DOCTOR	PRIMARY DOCTOR
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EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE #
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HAVE YOU RECEIVED HOME HEALTH IN THE PAST MONTH?	HAVE YOU RECEIVED PHYSICAL THERAPY IN THE PAST MONTH?
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WHAT PROBLEM BRINGS YOU TO THERAPY?	HAVE YOU RECEIVED THERAPY FOR THIS CONDITION BEFORE? (if yes, where)
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CURRENT MEDICATIONS (WE WILL BE HAPPY TO COPY YOUR MEDICATION LIST)

KNOWN ALLERGIES

PLEASE LIST PRIOR SURGERIES / HOSPITALIZATION (IN LAST 10 YEARS)

MEDICAL/SURGICAL HISTORY

	YES	COMMENTS		YES	COMMENTS
Respiratory (COPD)			Diabetes Mellitus		
Asthma			Cancer		
High Blood Pressure			Kidney/Urinary		
Low Blood Pressure			Epilepsy/Seizures		
Dizziness			Gastrointestinal		
Heart Disease			Heart Attack		
Circulation/Vascular			Stroke		
Arthritis			Skin Problems		
Osteoporosis			Pacemaker		
Psychiatric History			Joint Replacement		
Other			Pregnancy		

IS THERE ANYTHING NOT COVERED ON THIS FORM THAT WE NEED TO KNOW ABOUT? IF YES, PLEASE EXPLAIN

WHAT ARE YOUR **GOALS FOR TREATMENT**?

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE
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