ChoicePT
Concierge Physical Therapy & Fitness

1092 Duval Street, Suite 210
Lexington, KY 40515
859.271.1092 phone
info@choiceptlex.com
888.521.2925 fax
www.choiceptlex.com

Patient Demographics and Health History

Name:_____ Date of Birth:_____ Current Age:_____

Gender:_____ Marital Status: _____ Height:_____ Weight:_____#s

Driver's Licence #:_____ State Issued:_____ Social Security #:_____

Mobile Phone:_____ Home Phone:_____ Work/Other:_____

Email address:_____

May we leave a message related to your appointments or treatment? Yes / No Appointment Reminder: Email / Text / Voice / None

Address:_____ City:_____ Zip:_____

Occupation:_____ Employer or School:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Number(s):_____

Primary Insurance:_____ Secondary Insurance:_____

(if different from patient) Policy Holder/Subscriber Name:_____ Date of Birth:_____

During this calendar year, have you received any Physical Therapy for any condition? Yes / No If yes, how many visits?_____

Please check & describe below any of the following that apply or have applied to you:

___Heart Attack	___Diabetes: Type I or II	___Dizziness / Vertigo	___Epilepsy / Seizures: Date of last seizure:_____
___High Blood Pressure	___Rhematoid Arthritis	___Poor Circulation	___Cancer: Type_____
___Heart Surgery	___Osteoarthritis	___Stroke / TIA	___Recent Weight Loss or Gain:_____
___Abnormal Heartbeat	___Gout	___Head Injury	___Fractures:_____
___COPD / Asthma	___Osteoporosis	___Blood Clotting Disorder	*Females: Any chance you are pregnant? Yes / No

Other/Notes:_____

Medications you are currently taking:_____

_____

Allergies to medications, latex, or adhesives:_____

Do you smoke? Yes / Never / Quit Packs per day:_____ Years smoked:_____ Years/Months since you quit?_____

Describe your exercise habits:_____

Are there any religious/cultural/social issues that may influence your treatment?_____

***I certify this information is complete and accurate (please sign):_____ Date:_____

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History of Presenting Problem

For what issue are you seeking Physical Therapy?_____

When did your pain/symptoms begin?_____ Is this a result of a work injury / motor vehicle accident / neither?

If known, what is the cause?_____

Referring Physician:_____ Phone:_____ Next appointment:_____

Have you had any of the following, related to this problem? X-ray / CT / MRI / bloodwork / Ultrasound / Other:_____

Have you had any previous treatment for this condition?_____

Have you missed work/school/sports because of your symptoms? Yes / No Are you currently restricted from normal activities? Yes / No

What is your goal for your treatment here?_____

Is there anything else pertinent to your condition that we should know?_____

***I certify this information is complete and accurate (please sign):_____ Date:_____