Pain Relief and Physical Therapy

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Havertown, PA 19083

Phone (610) 789-9887

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www.PainRelief-PT.com

Date of Evaluation _____ **PT**_____

Name : _____DOB_____SS#_____

Address: _____

Phone: (Home)_____ (Work) _____
(Cell)_____ Email_____

Circle: Male or Female Single Married Divorced Other

Employer:_____ Student: Y or N School:_____

Insurance Co. Name: _____ ID # _____

Responsible Party: _____DOB_____SS#_____

Relation to above:_____

Secondary Insurance Co: _____ ID# _____

Responsible Party: _____DOB_____SS#_____

Relation to above_____

Whom may we thank for your visit _____

What is your chief complaint? _____Date of injury/problem/surgery: _____

Have you had X-Rays, CT Scans, MRIs, Bone Scans or other tests for your recent disorder? Y N

(We would appreciate copies of any reports you may have)

Have you had any Physical Therapy/Occupational Therapy in the last year ? **Y or N**

What are your goals for rehabilitation? _____
Please describe any significant injuries, for which you have been treated:
_____

Please list any medications you have taken in the last week and Prescription Medications that you take daily_____

Patient Signature:_____**Date:**_____

PT Signature:_____License #_____ Date:_____