OUTPATIENT INFORMATION FORM

Your Name: ______________________ Date: ______________

Please Check any of the following you have seen for this condition:

( ) MD ( ) DO ( ) DC ( ) DDS ( ) DPM ( ) PT ( ) OT ( ) Psychologist

Surgeries / Procedures: ______________________

Have you had any injections for this condition? ( ) Yes ( ) No When?__________ Did it help? ( ) Yes ( ) No

Have you been diagnosed with the following?

☐ TB ☐ Epilepsy ☐ Arthritis ☐ Amputations ☐ Heart Disease
☐ Vascular Disease ☐ Hepatitis ☐ Cancer ☐ Closed Head Injury ☐ Low Back Pain
☐ Pulmonary ☐ Shoulder Pain ☐ Respitory Failure ☐ Knee Weakness ☐ Assault Patients
☐ Neck Pain ☐ Multiple Trauma ☐ Ankle Fractures ☐ Tendonitis / CTD / CTS ☐ Depression
☐ Tendon Repair ☐ Multiple Sclerosis ☐ Gun Shot Wounds ☐ COPD ☐ Stroke
☐ CHF ☐ Diabetes ☐ High Blood Pressure ☐ Coronary Artery ☐ End Stage Renal Disease
☐ Pulmonary ☐ Neuropathy ☐ Cancer ☐ Other ______________________

Is the condition you are being seen for related to a car accident? ______________________

Do you have any allergies to medicines? ______________________

Please List All Medications Including Over-the-Counter Medications and Home Remedies

Name of Drug	Dose / Amount	Route	Frequency	D/C Date	Comments

What diagnostic tests have you had & results? ______________________

Are you currently working? Y N If yes, how much? ( ) Full Duty ( ) Restricted Duty

What are your job responsibilities? ______________________

How many work/school days have you missed? ______________________

What Critical Work Duties/Tasks have been affected by your injury/condition? ______________________

Is life safe at home? ______________________

What do you want to accomplish with your therapy? ______________________

The above information has been reviewed with the patient and therapist. ______________________

Patient Signature: ______________________ **Date:** ______________

Therapist Signature: ______________________ **Date:** ______________