MULLIGAN PHYSICAL THERAPY

Patient Information

Name:_____ Date:_____
Address:_____City:_____St.:_____Zip:_____
Phone: Cell #:_____ Home #:_____
Workl#:_____ E-Mail Address:_____
Occupation: _____ Currently working: Yes ☐ No ☐
Sex: ___M ___F Date of Birth:_____ Soc. Sec. #:_____
How did you hear about us? _____

Emergency Contact
1: Name: _____ Relationship:_____
Phone: Home:_____ Cell:_____ Work:_____
Do you give us permission to discuss your medical condition with this contact? Yes ☐ No ☐
2: Name: _____ Relationship:_____
Phone: Home:_____ Cell:_____ Work:_____
Do you give us permission to discuss your medical condition with this contact? Yes ☐ No☐

Referring Physician:_____ **Primary Physician**:_____
Why are you being seen for Therapy?_____
Were you injured at work? Yes ☐ No ☐
Were you injured in a car accident? Yes ☐ No ☐ Date of Injury: _____

Medical History: Height:_____ Weight: _____
Any Allergies? Yes ☐ No ☐
If Yes, Please list:_____
Are you currently taking medications? Yes ☐ No ☐
If Yes, Please list:_____

Please indicate any medical conditions or diagnoses that are part of your history:

__Asthma/Bronchitis/emphysema	__Coronary artery disease/angina	
__Pacemaker	__Heart attack/Heart surgery	
__High Blood Pressure	__Stroke/TIA	__Osteoporosis
__Pins or Metal Implants	__Pregnancy	__Vision/Hearing problem
__Joint Replacement	__Head Injury	__Epilepsy/Seizures
__Neurological Disorders	__ Arthritis	__Diabetes

__Other_____

☐ I agree to the release of medical or other information to process claim
☐ I agree to accept assignment of payment
☐ I give office permission to leave a message on my answering machine
☐ I give permission to discuss medical conditions with another physician
☐ I agree to have text/email appointment reminders sent to me

Patient Signature:_____ Date:_____