CONROY ORTHOPAEDIC AND SPORTS PHYSICAL THERAPY

# EVALUATION/PATIENT INTRO

PATIENT NAME_____DATE_____
ADDRESS (street and city)_____
AGE/D.O.B._____PHONE H:_____C:_____W:_____
OCCUPATION_____HT:_____WT:_____
ACTIVITIES (sports, hobbies)_____HAND DOMINANCE_____
DOI/DO_____DOS_____BODY REGION_____
DATE LAST WORKED_____PHYSICIAN_____

| ***Office only***: | ICD9 CODE |
|---|---|
| DIAGNOSIS _____ | _____ |
| COMORBIDITY/COMPLEXITIES _____ | |
| MECHANISM _____ | |
| PREMORBID EXPECTATIONS _____ | |
| INSURANCE STATUS: W.C. MEDICARE REGULAR HMO PPO SECONDARY LIABILITY OTHER | |

Employer_____

Employer address_____

Employer phone_____

Social Security #_____Email_____

Insurance carrier_____

Group #_____Medicare #_____

Work Injury YES/NO Contact person and phone_____

Referred by_____

Problem for which you were referred_____

Party responsible for injury_____

Medicare patients: Are you currently receiving home health care? YES/NO

Have you received any physical therapy or speech therapy this calendar year? YES/NO

Married/Single Number of Children and ages:_____

Typical day includes the following activities:_____

_____

Lives with/support person:_____