



re:fit, inc.
910 Waukegan Road
Glenview, IL 60025

(p) 847.657.0881
(f) 847.657.0882

Patient Information:

Name: _____

Address _____

City _____ State _____ Zip _____

Phone: (PLEASE CHECK THE PREFERRED NUMBER FOR MESSAGES)

HOME

WORK

CELL

What's the earliest/latest we can phone your home?

Email _____

Date of Birth: _____ Gender Identity: _____

Social Security Number: _____

Date of injury (If applicable): _____ Date last worked: _____

Emergency Contact:

Name: _____

Relation: _____

Phone Number: _____

Insurance Information:

Primary insurance holder: _____

Date of Birth: _____

Employer Name: _____

Insurance Company: _____

Phone: _____ Fax: _____

Insurance Plan Name: _____

ID number: _____ Group Number: _____

Referring Physician:

Name _____

Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____



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Patient Medical History

Please tell us about you:

Name: _____ **Age:** _____

Why were you referred to physical therapy?

Please describe how and when your injury occurred.

In the last year have you undergone any surgical procedures?

YES NO

In the last year have you been admitted to a hospital?

YES NO

If yes, what hospital? _____

What was the condition/surgery that required hospitalization?

Is this condition the reason you were referred for physical therapy?

YES NO

Have you received any physical therapy treatment during the past year?

YES NO

If yes, for what condition? _____

Where was this treatment administered? _____

Please tell us about your activities at work and at home: _____

Occupation: _____

Is the majority of your day spent:

SITTING STANDING WALKING

At the present time, what are the most difficult tasks for you to perform?

AT WORK: _____

AT HOME: _____



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Patient Medical History (Continued)

What is the heaviest object you lift at work? _____

What is the weight of this object? _____

How many times do you lift object daily? _____

Have you been able to work? YES NO

If No: What was the last day you worked? _____

If you are unable to work at your regular job, do you expect to return to other work?
 YES NO

Have you received any special tests related to your injury/condition? YES NO

If yes, please specify: _____

Are you taking any medications? YES NO

If yes: what type and for what condition? _____

Are you taking any supplements? If yes: what kind? _____

What is the heaviest object you lift at home? _____

What is the weight of this object? _____

How many times do you lift object daily? _____

What type of exercise activities are you currently doing, and how many times a week?

What are your hobbies? _____

What are your goals for therapy? _____



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Patient Medical History (Continued)

Do you have a history of:

- | | | | |
|-----------------------|--|-------------------------|--|
| Seizures | <input type="radio"/> YES <input type="radio"/> NO | Cancer | <input type="radio"/> YES <input type="radio"/> NO |
| Stroke | <input type="radio"/> YES <input type="radio"/> NO | Falls | <input type="radio"/> YES <input type="radio"/> NO |
| Diabetes | <input type="radio"/> YES <input type="radio"/> NO | Unexplained weight loss | <input type="radio"/> YES <input type="radio"/> NO |
| Dizziness | <input type="radio"/> YES <input type="radio"/> NO | Night Sweats | <input type="radio"/> YES <input type="radio"/> NO |
| Exposure/Treatment TB | <input type="radio"/> YES <input type="radio"/> NO | Cough over 2 weeks | <input type="radio"/> YES <input type="radio"/> NO |
| Fever over 2 weeks | <input type="radio"/> YES <input type="radio"/> NO | | |

Cardiovascular:

- | | | | |
|---------------------|--|---------------|--|
| High Blood Pressure | <input type="radio"/> YES <input type="radio"/> NO | Heart Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Pace maker | <input type="radio"/> YES <input type="radio"/> NO | | |

Bowel:

- | | | | |
|-----------------|--|-----------------|--|
| Gas: | <input type="radio"/> YES <input type="radio"/> NO | Bloating: | <input type="radio"/> YES <input type="radio"/> NO |
| Diarrhea: | <input type="radio"/> YES <input type="radio"/> NO | Constipation: | <input type="radio"/> YES <input type="radio"/> NO |
| Food Allergies: | <input type="radio"/> YES <input type="radio"/> NO | Blood in Stool: | <input type="radio"/> YES <input type="radio"/> NO |

Urogenital:

- | | | | |
|----------------------|--|---------------------|--|
| Urination Frequency: | During day: _____ | During Night: _____ | |
| Burning: | <input type="radio"/> YES <input type="radio"/> NO | Dribbling: | <input type="radio"/> YES <input type="radio"/> NO |

Women's Health:

Are you now or is there a chance that you may be pregnant? YES NO

Length of menstruation cycle: _____

Age at first period: _____

Date of last period: _____

Hot Flashes: YES NO

Night Sweats: YES NO

Do you use birth control: YES NO

Pain with intercourse: YES NO

Number of Pregnancies: _____

Number of full term: _____

Type of Delivery: VAGINAL YES NO

CESAREAN SECTION: YES NO

Episiotomy: YES NO

Complications: _____
