Gray Physical Therapy Center, PA
205 Portland Rd, Gray, ME 04039
Tel: (207) 657-5600 Fax: (855) 464--0106

Patient Data Sheet

MR #: ______________________

YOUR CONTACT INFORMATION

Name: ______________________ **DOB:** _____/_____/_____ **SSN:** ______________________

Mailing Address: ______________________ **Gender: M** __ **F** __ **Other** ___

Physical Address: ______________________ **E-mail:** ______________________

Phone Numbers: Home: ______________________ **Cell:** ______________________ **Work:** ______________________

How BEST TO contact you? ***E-mail*** ____________ ***Home #*** ____________ ***Cell #*** ____________

Emergency Contact: ______________________ ***Telephone:*** ______________________

Your Employer: ______________________ ***Address:*** ______________________

If Under 18 Years of Age: Responsible Party Name: ______________________ Relationship to you: ______________________
Address (if different from patient): ______________________ Telephone: ______________________

Doctor Sending you to PT: ______________________ Family Doctor (PCP) ______________________
Your Diagnosis– What are we seeing you for? ______________________ Onset Date: ______________________

BILLING / INSURANCE INFORMATION

Primary Health Insurer: ______________________
ID/ Certificate/ Policy Number ______________________
Subscriber's Name: ______________________ Your Relationship to the Subscriber: ______________________

Secondary Insurer: ______________________
ID/ Certificate/ Policy Number ______________________

If your injury is Worker's Comp or Motor Vehicle Accident related—please complete the following

Worker's Comp Insurer: ______________________
Claim Number ______________________ Claim Handler: ______________________ Claim Handler Phone: ______________________

Motor Vehicle Insurer: ______________________ Claim Handler: ______________________ Phone: ______________________
Case Number: ______________________

Attorney Name and / or Agency : ______________________ Attorney Phone: ______________________

How did you hear about Gray PT and what influenced your decision to come?

PATIENT MEDICAL HISTORY

Name:______________________________________ **Date:**_________________

Do you have problems with your: ☐ eyesight ☐ hearing ☐ ability to read ☐ ability to write

Check if you have or have had any of the following:

☐ pace maker ☐ lung disease ☐ cancer
☐ blood thinners ☐ arthritis ☐ broken bones (fractures)
☐ high blood pressure ☐ joint replacements ☐ osteoporosis
☐ high cholesterol ☐ diabetes ☐ stroke
☐ heart disease ☐ migraine headaches ☐ kidney disease
☐ chest pain ☐ epilepsy/seizures ☐ liver disease
☐ blood relative under 55 who suffered a stroke or heart attack

Have you fallen 2 or more times in the last year OR have you fallen one time resulting in injury? *Y / N*

List any *recent* (within last year) hospitalizations / reasons / dates: ____
____
____

List any *recent* surgeries and dates:____
____
____

MEDICATIONS AND SUPPLEMENTS (please complete or provide a separate list if not enough space)

	NAME	REASON (Pain, BP, Diabetes etc)	How Much (Mg)	How Often (per day or wk)	How Taken (mouth, inject)
Prescription Meds					
Over the counter Meds					
Supplement (vitamins)					

Medications I am allergic to: ____
Food and other things I am allergic to:____

Women: Is there a chance you may be pregnant? ☐ Yes ☐ No

I have completed and updated my information:

DATE	INITIALS	PT Initials

My height and weight

Height	Weight	BMI (PT use only)