515 Forrest Park Way
Greenwood, AR 72936
Phone: 479-996-5078
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GREENWOOD PHYSICAL THERAPY

Last Name: First Name: M.I: D.O.B

Street Address:_____

_____

City:_____ State:_____ Zip:_____

Email:_____

Phone:_____Contact Me:___Y___N

Sex: _____Male _____Female Handedness: _____Right _____Left

Do you live: _____ Alone_____ Spouse/Significant Other_____ Other

General Health Status:____ Excellent____ Good____ Fair____ Poor

Allergies: _____

_____

Occupation: _____ email address: _____

Have you completed an Advanced Directive? _____ Yes _____ No SSN #: _____- _____- _____

Do you require any Assistive Devices (i.e. walker, cane, wheelchair)? If so, please describe:

Past Medical History (check all that apply):

___ Arthritis	___ Pacemaker	___ Cancer	___ Diabetes	___ CHF
___ Cardiac	___ High Blood Pressure	___ Osteoporosis	___ Parkinson Disease	___ Skin Disease
___ Alzheimer Disease	___ Head Injury	___ COPD	___ Tuberculosis	
___ Fractures	___ Seizures	___ Stroke/CVA	___ Infectious Disease (HIV,HEP)	

Please list any other medical conditions not listed above:

Previous Surgeries and Dates:

_____

_____

_____

DO YOU CURRENTLY HAVE A PACEMAKER OR IMPLANTED

DEFIBRILLATOR OR DEVICE? _____YES _____NO

Women: Are you currently pregnant or think you may be pregnant?

_____Yes _____No

Reason you are seeking Physical Therapy treatment:_____

_____

Date problem began:_____ Are you currently receiving home health nursing or therapy: Y N

Previous Treatments for current condition:_____

Emergency Contact Information: _____