Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 727-216-3492

Name: _____

(**Please PRINT**)

Preferred Name: _____ Email: _____

Address: _____

City, State, Zip: _____

Home Phone Number: _____ Cell Phone: _____

Work Phone Number: _____ **Best Way** to Reach You: Home Cell Work

Birth Date: _____ Marital Status: S M W D P

Occupation: _____ Employer: _____

Emergency Contact (Name, Relationship & Phone Number): _____

_____

Do You Smoke? Y N How Much? How Often? _____

Drink Alcohol? Y N How Much? How Often? _____

Primary Physician's Name: _____ PCP's Phone: _____

Referring Doctor's Name: _____ Dr.'s Phone #: _____

**********This info is only needed if using Medicare or VA Choice**********

Insurance (circle): **Medicare** **VA Choice**

Relationship to Insured: _____ Insured's Full Name: _____

Insured's SS#: _____ Insured's Birth Date: _____

Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 727-216-3492

Name: _____ Birth Date: _____

YOUR MEDICAL HISTORY

HEAD
___ Brain Injury
___ Seizures
___ Aneurysm
___ Encephalitis

EYES
___ Glaucoma
___ Cataracts

EARS
___ Miniere's
(Type: _____)
___ Hearing Loss

THROAT
___ Sleep Apnea
___ Snoring
___ Thyroid Disease

LUNGS
___ Emphysema
___ Pleurisy
___ Pneumonia
___ Asthma

HEART
___ Atrial Fibrillation
___ Blood Clots
___ High Blood Pressure
___ Defibrillator
___ Pacemaker
___ Irregular Heart Rate

JOINTS
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Gout
___ Osteoporosis
___ Osteogenesis Imperfecta
___ Broken Bones:
(_____)

NEUROLOGICAL
___ Multiple Sclerosis
___ Polio
___ Parkinson's
___ Stroke
___ Meningitis

GYN
___ # of Pregnancies
___ Cramps
___ Endometriosis
___ Fibroids

ENDOCRINE
___ Diabetes Mellitus Type 1
___ Diabetes Mellitus Type 2
___ Hypoglycemia

DISEASES
___ HIV / AIDS
___ Hepatitis
___ TB

MISCELLANEOUS
___ Cancer
(Type: _____)
___ Anxiety
___ Depression
___ Panic Attacks
___ Migraines
___ Fibromyalgia
___ GERD (Acid Reflux)

OTHER: _____
_____

SURGERIES: _____
_____

Allergies: _____
Current Prescription Medications: _____
_____
Current Over the Counter Medications: _____
Vitamins / Supplements / Herbs: _____
_____

Privacy Statement: Your information will be shared only with your doctors or other healthcare practitioners directly involved in your case. If using insurance, information will be sent to insurers as requested.

People we may talk to about your status: _____

PHYSICAL THERAPY PATIENT HISTORY Today's Date: _____

Name: _____

Height: _____ Weight: _____

Reason for today's visit: _____

Have you seen a doctor for this problem? _____

What Tests/Surgeries have you had done for this problem? _____

Other current Therapies: _____

When did this problem begin? _____

What caused this problem? _____

Rate Your Pain and/or Swelling on a Scale of 0 – 10 (0 = NO Pain; 10 = Go to the Emergency Room) :

At it's Best _____ At it's Worst _____ Today _____

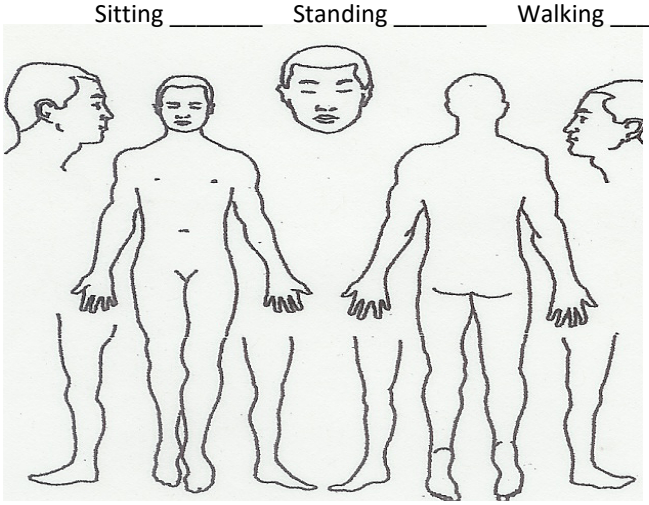
Is Your Pain and/or Swelling Constant? _____ Does it Come and Go? _____

Is it Worse in the Morning? _____ Midday? _____ in the Evening? _____

How Often do You have this Pain and/or Swelling? _____

Activities or Movements that are Painful to Perform: Reaching_____ Lifting_____

Sitting _____ Standing _____ Walking _____ Bending _____ Lying Down _____



Please mark on this drawing

Areas where you have

Pain and/or Swelling.

Limitations you Currently have due to your Pain and/or Swelling. (Sleep, Self-Care, Socializing, etc.): _____

_____

_____

Previous activity level, including exercise, recreation, job, etc.: _____

_____

_____

Do you have any difficulty getting around your home? If so, Explain: _____

_____

Do you live in a House? _____ Apartment? _____ Condo? _____ Mobile Home? _____

Do you, Live Alone? **Yes** **No** If No, you Live With _____

Number of Steps to Enter home: _____ Number of Steps Inside home: _____

What is your Goal for this therapy?: _____