142 Franklin Farm Lane
Chambersburg, PA 17202

Phone: 717-263-5147
Fax: 717-263-3454

www.physicaltherapyetc.com

PHYSICAL THERAPY etc.

Patient History – Adult

(Please fill in all spaces to the best of your ability)

Name: _____

Date of Birth_____ Age_____

Address:_____

City: _____ State:_____ Zip:_____

Preferred Phone Contact:_____

Referral Source:_____

**Reason for Visit Today**

Concerns with: **speech** **language** **voice** **cognition** **swallowing** **other**

_____

_____

_____

**Have you received speech-language services before?** **Yes** **No**

If yes, when?_____

Where?_____

**Medical History:**

Please list **ALL** recent illnesses, injuries, hospitalizations, **ALL** diagnosed conditions:-

_____

_____

_____

List known allergies:

_____

_____

Have you had problems with or changes in (circle yes or no for each)

Hearing: Yes No

If yes, when?_____

Vision: Yes No

If yes, when?_____

Breathing: Yes No

If yes, when?_____

Swallowing: Yes No

If yes, when?_____

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**Education and Work History**

Last grade completed_____

Occupation_____

Currently working? Yes No

Recreational Activites_____

**Additional Information**

Is there anything else you would like us to know about you?

_____

_____

_____

_____

_____

Patient or Guardian Signature

_____

Relation to Patient

_____

Date