COMPASS
PHYSICAL THERAPY SPECIALISTS
Moving you in the right direction.

8801 N 32nd street, Richland, MI 49083
Phone: 269-203-7385 Fax: 269-216-7634

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: _____

I am currently: ☐ Employed ☐ Employed with restrictions ☐ On medical leave ☐ Not employed

Interests/hobbies are:_____

Is there anyone who can assist you with doing home exercises, if needed? ☐ Yes ☐ No

Will you have any problems attending therapy sessions? ☐ No ☐ Yes

General Health

1. Activity level: ☐ Low ☐Medium ☐ High

2. Are you having trouble sleeping? ☐ Yes ☐ No

3. Please check medical conditions you have or have had:

☐ High Blood Pressure
☐ Stroke
☐ Diabetes
☐ Weight Gain or Loss
☐ Arthritis
☐ Cancer
☐ Heart Disease
☐ Lung Disease
☐ Vision / Hearing Problems
☐ Depression
☐ Heart Attack
☐ Asthma
☐ Stomach Disorders
☐ Pace Maker
☐ Pregnancy (current) _____ wks
☐ Smoker
☐ Gland Problems
☐ Kidney or Bladder Control
☐ Anxiety

4. Are you taking any medications including over the counter, prescription, herbs, supplements, vitamins? ☐ Yes ☐ No

If yes, please list:

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_____
_____
_____

5. Do you have any allergies (eg. adhesives, latex, cortizone)? ☐Yes ☐ No If yes, please list with any reactions/treatments:

_____
_____
_____

6. Please list any major or recent surgeries or serious injuries:

_____
_____
_____

7. What is the level of your pain?

No pain — Worst Pain

PERSONAL GOALS FOR THERAPY

8. What do you WANT TO achieve from having therapy? Check all that apply:

☐ Improve home activities
☐ Improve leisure/sports activities
☐ Improve self care activities
☐ Improve mobility/walking activities
☐Improve ability to communicate
☐ Improve swallowing
☐ Decrease or eliminate pain/discomfort
☐ Return to work: ☐ Current job ☐ Other job
☐ Other_____

9. Please include any additional information you feel would help us provide your care (ie. what you think would help, any apprehensions about treatment, spiritual or cultural needs).

_____
_____

To the best of my knowledge, the above information is complete and factual.

Patient Signature: _____ Date: _____