



PREMIERE REHAB, LLC

Phone (317) 542-7680
Fax (317) 542-7682
PremiereRehab@sbcglobal.net
www.PremiereRehab.org
9505 E. 59th Street, Suite B1
Indianapolis, In 46216

Name: _____ Age: _____ DOB: _____ Phone: _____

Referred by: _____

Primary Care Physician (if different then above): _____

Employment: Full Time Part Time Unemployed Retired Student

Dominant Hand: Right Left

Prescription Medications: _____

Surgical History: _____

Have you received physical therapy treatment this calendar year? Yes No

Medical History (check all that you have ever had):

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Lung Problems | Other: _____ |
| <input type="checkbox"/> Osteoporosis | |

Positive TB in last 12 months ? _____

Are you having any of these symptoms? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness |

Are you pregnant? Yes No

Do you feel that you require Social Services ? _____

History of current problems:

What is your condition/injury? _____

When did the problem(s) begin? _____

What happened? _____

Have you had the problem(s) before? Yes No

What makes problem(s) worse? _____

What makes problem(s) better? _____

Current Limitations (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Difficulty with walking | <input type="checkbox"/> Difficulty with chores, shopping, driving |
| <input type="checkbox"/> Difficulty with stairs | <input type="checkbox"/> Difficulty with work, school |
| <input type="checkbox"/> Difficulty with walking on rough ground | <input type="checkbox"/> Difficulty with recreational activities |
| <input type="checkbox"/> Difficulty with bathing, dressing, eating | |

I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Patient Signature: _____

Date: _____