Fairway Physical Therapy
7100 Fairway Drive suite 26 & 27, Palm Beach Gardens 33418
561-775-7775 Phone
561-775-7807 Fax

_____/_____/_____
Today's Date

Patient information

Patient name: _____ _____ _____
Last First MI

Date of Birth: _____/_____/_____ **Gender**: Male_____Female_____

_____ _____
Social Security number **E-Mail address (optional)**

Martial Status: Married_____Single_____Widowed_____Divorced____

Permanent Address: _____

_____ _____ _____
City State Zip

Local Address (If other than Permanent) _____

_____ _____ _____
City State Zip

_____ _____ _____
Home Phone **Cell Phone** **Work Phone**

Emergency Contact Information

Person to Contact in Case of Emergency _____ _____
Last First

_____ _____
Relationship phone

Employment Information

Employer: _____

Employer Address: _____

_____ _____ _____
City State Zip

Employer Phone: _____ Work status: _____
Name_____

Are you now taking Medicine? (including non-prescription and dosage) _____ Yes No

_____

_____

Have you had any serious illness(es), operation(s) or hospitalized in the Past 5 years? Yes No

Explain _____

Do you have or have you had nay of the following diseases or problems?

Alcoholism	Yes	No	Hearing problems	Yes	No
Allergies	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	Hypertension	Yes	No
Bowel	Yes	No	Pacemaker	Yes	No
Caner	Yes	No	Immune System	Yes	No
Circulatory	Yes	No	Liver Disease	Yes	No
Depression	Yes	No	Mental Illness	Yes	No
Diabetes	Yes	No	Renal Disease	Yes	No
Drug Abuse	Yes	No	Respiratory	Yes	No
G.I. Disturbance	Yes	No	Seizures	Yes	No
Gout	Yes	No	Stroke	Yes	No
Total Hip Replacement	Yes	No	Total Knee Replaced	Yes	No

Do you have any disease or problems not listed above that you feel we should know about? Yes No

If yes please explain_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the program or any of it's staff responsible for any errors or omissions that I have made in the completion of this form.

I hereby authorize you to release a brief history in your possession concerning my injury/ illness and treatment to my referring physician.

_____ _____

Patients Signature (or person completing for patient) Date