Integrity Therapy, P.C.

4306A Crystal Lake Rd.
McHenry, IL 60050
Phone: 815-385-7090

TODAYS DATE:	**PATIENT INFORMATION**	
Patient's Last Name:	First Name:	Birth Date:
Spouse's Name:	Spouse's Birth Date:	Marital Status:
Street Address:	City:	State: Zip Code:
Home Phone:	Cell Phone:	
Can we leave messages and correspond by mail with the information provided above? ❑ Yes ❑ No		
Physician Name:	Last Office Visit:	
Diagnosis/Surgical Procedures:		
Date of Procedure:	Discharge Date:	

(CHECK ALL THAT APPLY)	**MEDICAL HISTORY**	
❑ Hypertension	❑ Cardiac	❑ Diabetes
❑ Respiratory	❑ Osteoporosis	❑ Fractures
❑ Cancer	❑ Infection	
❑ Other:		❑ Height: ❑ Weight:

Previous Hospitalizations:	Date:	Reason:
Date:	Reason:	
Date:	Reason:	

Are you experiencing pain? ❑ Yes ❑ No	How Often?
Pain location(s):	
Please rate from 0-10 with, 0=No Pain and 10=Worst Possible Pain	

Present level of pain:	Worst pain gets:	Best pain gets:

Type of pain:	❑ Nagging	❑ Heavy	❑ Stabbing	❑ Throbbing	❑ Aching	❑ Dull	❑ Sharp
	❑ Tingling	❑ Cramping	❑ Radiating	❑ Burning	❑ Other		

Current Medications: **If Medicare, as a requirement, please complete included *Medication Record* form to list specific dosages, frequency and time of each medication.**

Allergies:

Physical therapy expectations/goals:

Previous physical therapy this last year: