SHELBYVILLE PHYSICAL THERAPY AND SPINE CARE CENTER, P.S.C.

HISTORY FORM

Name: _____

Date of birth: _____ Employer: _____

Spouse's /Parent's name: _____

Spouse's/Parent's date of birth: _____

Spouse's/Parent's SS#: _____

Spouse's employer: _____

Please list all medications that you are currently taking:_____

_____

_____

_____

_____

_____

_____

Please list any diagnostic testing that you have done and where you had them done, that may be relevant to your visit with us today.

_____

_____

_____

_____

_____

By signing this form, I verify that all of the above information is correct to the best of my knowledge. I am also giving Shelbyville Physical Therapy & Spine Care Center permission to request any diagnostic testing that I have had done that would be pertinent to my treatment.

_____ _____

Signature **Date**