Prostaff Physical Therapy
7609 Brockway Road
Yale, MI 48097
Phone: 810-387-4900
Fax: 810-387-9200

Patient Name:_____ Date of Birth:_____

Accident Information

Date of Accident/Injury: / /
Was this incident due to work? Y/N If so, Claim Number_____
Was this injury due to an auto accident? Y/N If so, Claim Number_____
State accident occurred:_____
Please explain the nature of the injury:

Medical History

Are you receiving any type of home health care? Y/N
Have you received any home health care in the last 30 days? Y/N
Have you received any physical therapy in the last year? Y/N
If so, when_____ Where_____
Have you taken cortisone by pill in the last 5 years? Y/N

Past history of injuries/accidents/surgeries (Please put an * next to the hospitalization dates related to the current injury)

Description: Date of incident/injury:

High Blood Pressure	Y/N	Autoimmune Disease	Y/N	Latex Allergies	Y/N
Cancer	Y/N	Kidney/Bladder Disease	Y/N	Other Allergies	Y/N
Diabetes	Y/N	Thyroid Disease	Y/N	Do you smoke	Y/N
Heart Disease	Y/N	Skin Disease	Y/N	Are you pregnant	Y/N
Lung Disease	Y/N	Fibromyalgia	Y/N		
Stomach Disorders	Y/N	HIV Positive	Y/N		
Liver Disorders	Y/N	Bleeding Tendencies	Y/N		
Arthritis	Y/N	Circulation Problems	Y/N		
Rheumatoid Arthritis	Y/N	Psychiatric Diagnosis	Y/N		

Tuberculosis Screen

In compliance with the government regulations, we must have each patient complete the following questionnaire

1. Have you ever been diagnosed with TB(Tuberculosis)? Y/N
2. Have you been living with anyone in the past two years who has been diagnosed? Y/N
3. Have you had a persistent cough and night sweats for more than two years? Y/N
4. Have you had a persistent cough and fever for more than two weeks? Y/N
5. Have you had a persistent cough and loss of appetite for more than two weeks? Y/N
6. Have you been coughing or spitting up blood sputum(saliva)? Y/N