

LONG ISLAND UNIVERSITY CENTER FOR PHYSICAL REHABILITATION

GENERAL INFORMATION

Name _____ Date _____

 Last First MI

Address _____

City _____ State _____ ZIP _____

Telephone Home _(____) _____ Work _(____) _____

e-mail _____

DOB _____ Age _____ SS# _____

MEDICAL INFORMATION

Diagnosis _____

Referring Physician _____

In case of emergency, please notify _____

 Relationship _____

 Telephone Home _(____) _____ Work (____) _____

PHYSICAL THERAPY GOALS

Please list goals you would like to achieve through rehabilitation. Please be specific.

1. _____

2. _____

3. _____

4. _____

5. _____