DR. ABIGAIL C. CAVALLO, DPT

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PHONE (631) 265-5702 FAX (631)265-9014

PERSONAL HISTORY

Date: _____
Name: _____
Address:_____
City_____ State_____ Zip Code _____
Home#: _____ Cell#:_____ Work#:_____
Email Address: _____
Date of Birth: _____ Marital Status_____ Referred By_____
Emergency Contact Name and Phone # _____
Primary Care Physician: _____ Phone Number_____

☐ **No insurance changes from previous document**
Primary Insurance Company: _____ Phone Number: _____
ID#:_____ Group#:_____

Insured's Name: _____ Relationship: _____
Address: _____
_____
Date of Birth of Insured: _____
Occupation & Employer: _____

Secondary Insurance: _____ Phone Number: _____
ID#: _____ Group#: _____

Insured's Name: _____Relationship: _____
Address: _____
Date of Birth of Insured_____
Occupation & Employer_____

Do you take any Medications? ☐ Yes ☐ No ☐ No medication changes from previous visit
If yes, please list all medications and what they are taken for: _____
_____
_____

Do you have any allergies to Medications? ☐ Yes ☐ No ☐ No new medication allergy changes from previous visit
If yes, please describe medications:_____
_____

Past Surgeries?_____

Please Circle any conditions you have/had:

Hypertension	Osteopenia	Active Cancer If yes, what type_____
Diabetes- Type 1 or Type 2	COPD	
Hyperlipidemia	Emphysema	Neurological Condition If yes, what type_____
Osteoarthritis	Heart Failure	
Rheumatoid Arthritis	Anemia	Other_____
Osteoporosis	Dizziness	

Are you a Smoker? ☐ Yes ☐ No ☐ Current smoker ☐ Ex-smoker ☐ Never smoked

Height: _____ Weight: _____ Blood Pressure: _____

Signature_____ Date_____