Patient's Information

(Circle one): New Patient / Return Patient Patient #(Front desk will provide):____________________

Name: First:______________________________Middle:____________________Last:________________________________

Street Address:____

City:____State:________________Zipcode:_____________________________

Cell Phone:___________________________________Home/Alternate Phone #:__________________________________

Date of Birth:____________________________Age:____________Social Security #:________________________________

Marital Status (circle one): Married / Single / Widowed / Separated / Divorced

E-mail:_________________________________Emergency Contact Name and #:_________________________________

Employment Information

(Circle one): Employed / Unemployed / Retired / Student

Employer/ School:__________________________________Occupation:____________________Phone #:____________

Employment Address:______________________________City/State/Zipcode:__________________________________

Spouse and Parent Information

Spouse/ Parent Name:____Phone #:______________________________

Address:____City/State/Zip Code:_______________________________

Date of Birth:_________________________________Employer:____

Insurance Information

Primary insurance:____

Secondary insurance:____

***Please provide the front desk with your insurance card so we may make a copy for your file.*

Physician Information

Referring Physician:___________________________________Primary Physician:_____________________________________

How did you hear about us?

Please check one:

☐Returning patient ☐Phonebook

☐Physician ☐Word of Mouth

☐Internet *Name of referrer*________________

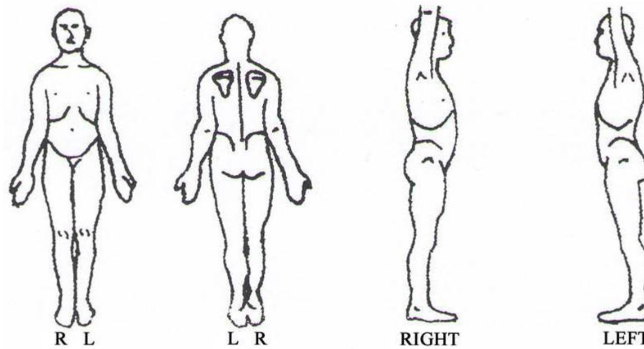
☐Employer ☐Other

*List other*______________________

Patient Medical History

Height:_____ft._____in.

Weight:__________lbs.



Where are your symptoms located? (Darken the spots on the appropriate body above)

When did your symptoms begin?____

Circle the words that best describe your symptoms: sharp / dull / burning / cramping / localized / radiating

Are your symptoms due to an accident or trauma?(describe)____

What makes you feel better?____

What makes you feel worse?____

Please rate the following on a scale of 0-10 (0 being no pain, 10 being the worst pain you can imagine):

1. The least pain you've had in the past week: _______ out of 10
2. The most pain you've had in the past week: _______ out of 10
3. Your current level of pain: _______ out of 10

Please list any relevant medical history:______________________________________

Please provide all current medications you are taking, including dosage (if multiple, please provide a list for the chart):______________________________________

Please list any diagnostic test results (X-rays, MRI, CT scan, Myelogram, etc.):__________________

____

Please list any interventions prior to physical therapy (injections, splints, medications, etc.):____

If 100% represents full recovery and full functioning for you, what percent are you at today?__________

Do you have any previous medical problems that may limit your ability to exercise?
(Circle one): Yes / No

If yes please explain:

____

Please mark if you had or have any of the following problems (choose all that apply):

☐ Pace maker
☐ Heart attack
☐ Headaches
☐ Stroke
☐ Heart Disease
☐ Hepatitis
☐ Infections
☐ Diabetes
☐ Cancer
☐ Hernia
☐ High Blood Pressure
☐ Bowel/Bladder
☐ Metal Implants
☐ Dizziness
☐ HIV
☐ Insomnia

Females only: Pregnant: ☐ Yes ☐ No