NEW PATIENT INFORMATION

Please print clearly

Name: (First)_____ (Last)_____ (M.I.)_____

Address: _____

City_____ State_____ Zip_____ Home Phone: _____

Cell Phone: _____ Text Messages: Y / N Email: _____

Social Security Number:_____ Date of Birth:_____ Age:_____Sex: M / F

Emergency Contact:_____Telephone:_____Relationship: _____

Referring/Primary Care Physician: _____Phone: _____

Social: Married / Single / Divorced / Separated / Widowed Have you been hospitalized in the past 60 days? Y / N

Employment: Full-Time / Part-Time / None / Retired / Student Employer: _____

Have you had ***physical therapy/ occupational therapy/chiropractic treatment*** this calendar YEAR? Y / N

If Yes, where? _____ Number of Visits: _____

How did you hear about us? *Returning Client Friend/Family Referring MD Self Referred Staff Social Media Website Internet Search Location/Signage Community Event Employer/Insurance Other:*_____

PAST MEDICAL HISTORY: ***Please check any condition that you currently have or have had in the past***

☐High Blood Pressure	☐Liver Disease	☐Arthritis: OA / RA	☐Cancer:_____
☐Lung Disease/COPD/Emphysema	☐Stroke	☐Fibromyalgia/Chronic Pain	☐Anemia
☐Heart Disease/Problems	☐Kidney Disease	☐Epilepsy/Seizures	☐Osteoporosis
☐PACEMAKER	☐Diabetes	☐Bowel/Bladder Dysfunction	☐Scoliosis
☐Asthma/Allergies	☐Angina	☐Recent Infection	☐Anxiety
☐Thyroid Problems:_____	☐Lyme Disease	☐Headache/Migraine	☐Lupus
☐Circulation/Bleeding Problems	☐Blood Clots	☐Chemical Dependency	☐Hernia
☐Multiple Sclerosis	☐Depression	☐Hepatitis	☐Tuberculosis
☐Sexually Transmitted Disease	☐Parkinson's	☐HIV	☐Other:_____

Currently, I am experiencing the following (check all that apply):

☐Unexplained Weight Loss/Gain	☐Difficulty Swallowing	☐Dizziness/ Lightheadedness
☐Increased Pain at Night	☐Headaches	☐ Changes in Bowel/Bladder Function
☐Fever / Chills / Sweats	☐Nausea / Vomiting	☐Depression
☐Changes in Appetite	☐Loss of vision/ Double vision	☐Shortness of Breath
☐Blood in Urine/ Stool	☐Numbness or Tingling	☐Excessive Fatigue
		☐Other: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Y / N
During the past month, have you often been bothered by little interest or pleasure in doing things? Y / N

Are you allergic to latex? Y / N Do you live alone? Y / N Are you pregnant? Y / N
Do you smoke? Y / N Have you fallen over the past 12 months? Y / N If so, how many times? _____

Please list leisure activities/hobbies/exercise routine: _____

What activities comprise your typical day: Sitting / Standing / Walking / Lifting / Other:_____

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CURRENT CONDITION:

Describe the reason you are here? _____

_____

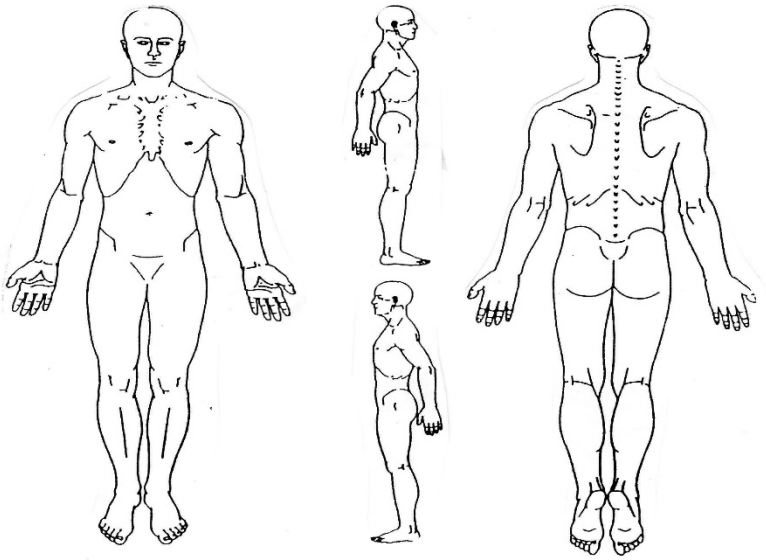
How did symptoms occur? ☐ Gradually ☐ Suddenly ☐ Injury: Home / Work / Auto / Sports / Other

When did symptoms start? _____ Symptoms are: ☐ Getting Better ☐ About Same ☐ Getting Worse

Have you ever had this problem before? Y / N Previous Treatments:_____

Have you had diagnostic imaging for this problem? X-ray / MRI / Ultrasound / CT Scan / EMG / Myelogram

Please mark symptom location/type on the diagrams below using these symbols:
(^^^ Numbness) (Pins & Needles) (xxxx Pain)***



Type of Pain: ☐ Ache ☐ Deep ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Stabbing ☐ Throbbing
Other:_____

Please rate your pain using 0-10 scale:
(0 is no pain at all, 10 is worst pain imaginable)

Current: 0 1 2 3 4 5 6 7 8 9 10

Least: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

What makes pain worse:_____

_____

What makes pain better:_____

_____

Please list ALL medications you are currently taking or use attached Medicare Medication Log:

_____

_____

_____

Please list prior surgeries including dates:

_____

_____

What are your physical therapy and/or fitness goals (write out or complete the sentence that applies to you)?

☐ Decrease pain with: _____

☐ Improve ability to:_____

☐ Leisure activities/Workout Routine:_____

The information above is HIPPA protected and is complete, true, and accurate to the best of my knowledge:

*Patient Signature:*_____ *Date:*_____

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Medication Log for Medicare Patients

Name: ____ **Date:** ____________________

Height: ______________________ **Weight:** ____________

Medicare requires that we collect data on the specifics of medications you use. Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
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		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other: