New Patient Information

Name_____ Email:_____ Date____/____/____

Address_____ City_____ State _____ Zip_____

Home Phone(____)_____ D.O.B.____/____/____ S.S.#_____

Marital Status _____ Emergency Contact_____ Phone(____)_____

Employment Information:

Employer_____ Address_____

Occupation_____ Work Phone #(____)_____

Referral Information:

Referring Physician_____ Phone #(____)_____

Diagnosis_____ Date of Onset_____

Describe the problem(s) for which you seek physical therapy.

_____

What happened?_____

What are your goals for physical therapy?_____

Are you seeing anyone else for your condition(s)?

☐Acupuncturist	☐Chiropractor	☐Massage Therapist	☐Osteopath
☐Orthopedist	☐Rheumatologist	☐Neurologist	☐Cardiologist
☐OB/GYN	☐Other(s)_____		

How did you find our facility?_____

General Health Status:

Please rate your health: ☐Excellent ☐Good ☐Fair ☐Poor

Have you had any major life changes in the past year? (i.e.: baby, job change, death in family) ☐Yes ☐No

Do you currently smoke? ☐Yes ☐No Have you smoked in the past? ☐Yes, year quit_____ ☐No

How many days/week do you drink alcoholic beverages (on average)?_____

How many drinks do you have on an average day?_____

Do you exercise beyond normal daily activities and chores? ☐Yes ☐No

How many days/week?_____ Describe exercise. _____

_____

Family History:

Indicate whether you mother, father, sibling suffered from any of the following condition(s) and age of onset if known.

☐Heart disease_____ ☐Hypertension_____ ☐Stroke _____ ☐Cancer_____
☐Diabetes_____ ☐Psychological _____ ☐Arthritis _____ ☐Osteoporosis_____
☐Other_____

Medical/ Surgical History: *(Check if you have ever had any of the following.)*

☐Arthritis	☐Broken bones/ fractures	☐Multiple Sclerosis	☐Epilepsy/Seizures
☐Vascular Disease	☐Heart problems	☐Skin Disease	☐Prostate Disease
☐Stroke	☐Allergies	☐Pregnancy	☐Growth Problems
☐Lung Problems	☐Head Injury	☐Recent Pregnancy	☐Infectious Diseases (Hepatitis)
☐OB/GYN Problems	☐Muscular Dystrophy	☐Low Blood Sugar	☐Blood Disorders
☐Parkinson	☐Thyroid Problems	☐Ulcers/Stomach	☐Pelvic Inflammatory Disease
☐Osteoporosis	☐Cancer	☐Kidney Problem	☐Depression
☐Diabetes/High Blood Pressure		☐Complicated Pregnancy	

☐Recent injury_____

☐Other_____

Within the past year have you had any of the following symptoms? *(Check all that apply.)*

☐Chest Pain	☐Shortness of breath	☐Joint pain/swelling	☐Loss of appetite
☐Bowel problems	☐Urinary problems	☐Hearing problems	☐Heart palpitations
☐Loss of balance	☐Pain at night	☐Nausea/vomiting	☐Weight loss
☐Fever/chills/sweats	☐Vision problems	☐Cough	☐Coordination problems
☐Difficulty walking	☐Difficulty sleeping	☐Weight gain	☐Headaches
☐Weakness in arms	☐Weakness in legs	☐Dizziness/ blackouts	☐Difficulty swallowing

☐Other_____

Medications:

Do you take any prescription medication? ☐Yes ☐No
If yes please list:_____

_____

Do you take any nonprescription medication? ☐Yes ☐No

Check all that apply.

☐Advil/ Aleve ☐Aspirin ☐Tylenol ☐Antihistamines ☐Decongestants
☐Herbal supplements ☐Antacids ☐Other_____

Within the past year, have you had any of the following tests? (Check all that apply.)

☐Angiogram	☐Arthroscopy	☐Biopsy	☐Bone scan	☐Blood tests	☐CT scan
☐EKG	☐Myelogram	☐Nerve conduction	☐Stress test	☐X-rays	☐MRI

☐Other_____

- Comments_____

_____