New Patient Form

Name (First) ________________ **(Last)** ______________________ **(M.I.)** __________

Mailing Address ____

City _______________________ State ________________ Zip _________________

Home Phone (   ) ____________ Work Phone (   ) ____________ Other (   ) ______

Social Security # ___________________ Birth Date ____________ Age ____ Sex: M/F

If Minor: Parent/Guardian Name ____

Social Security # ___________________ Birth Date ____________

Patient Marital Status: Married/Single/Divorced/Widowed/Separated

Student: No/Full-time/Part-time Spouse's Name _________________________

Emergency Contact ___________________________ Telephone _________________

Referring Physician __________________________ Telephone _________________

Primary Physician ___________________________ Telephone _________________

Whom may we thank for your referral to our facility? ___________________________

Patient Employer _______________________

Employment: Full/Part-time/Not Working/Retired

Address _______________________________ Occupation _______________________

Injury Type ☐ Work ☐ Auto ☐ Home

☐ Other _______________________________ Date of Injury _____________________

Attorney Involved Yes/No If yes, Attorney Name _________________________

Attorney Address _______________________ Telephone (   ) ____________________

Patient/Guardian/Responsible Party ____

Date __________________

Medical History

Patient Name ______________________________ Age __________
Type of Injury/Condition ______________________ Onset/Injury Date __________
Type of Surgery & Date ______________________________
Next Doctor's Appointment? ______________________________

Describe previous treatment of the condition ______________________________
Have you received physical therapy treatment this year? Yes/No
Have you received home health care this year? Yes/No

Have you had any imaging performed?

☐X-Ray ☐CT Scan

☐MRI ☐Doppler

☐Ultrasound

Have you recently noted: **Please Mark the Areas of Concern**

☐Weight Loss/Gain ☐Nausea/Vomiting ☐Numbness/Tingling

☐Weakness ☐Fever/Chills/Sweats ☐Change in Vision/Hearing

☐Pregnant/IUD ☐Headaches ☐Insomnia

☐Pain at Night ☐Cramps in Legs When Walking

Do you have now or have you ever had any of the following?

☐Surgeries ☐Loss of Consciousness ☐Fractures

☐Sprains/Strains ☐Diabetes ☐Blood Pressure Problems

☐Heart Problems ☐Cancer ☐Motor Vehicle Accident

☐Circulation Problems/Clots ☐Asthma/Breathing Problems ☐Lung Disease

☐Easy Bruising/Bleeding ☐Leg/Ankle Swelling ☐Urinary Problems/Infections

☐Indigestion/Heartburn ☐Fainting/Seizures ☐Allergies/Skin Sensitivity

☐Pacemaker ☐Metal Implants

Any previous injury that may affect your current care ______________________________
Explain and give approximate dates for any items indicated above ______________________________

____

Are you currently taking any medication? Yes/No
If Yes, Name or type of medication ______________________________
Type of Pain: Sharp/Burning/Aching/Tingling/Numbness/Other ______________________________
Rate your pain (1 = minimal, 10 = severe) **At its worst** 1 2 3 4 5 6 7 8 9 10 **At its best** 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? ____

____

What are your physical or fitness goals? ____

____

Is there anything else you would like to include or ask your physical therapist? ______________

____

____

Patient/Guardian/Responsible Party **Date**