NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:______________

Name (Last) ___________________________________ (First) ______________________________ (M.I.) _________

Home Address____

City____ State__________ ZIP________________________

Home Phone (_____)_______________ Cell Phone (_____)_______________ Work Phone (______)_______________

Email __________________________________ How shall we contact you? (circle) Home Ph. / Cell Ph. / E-mail / Text

Birth Date______________________ Social Security____________________________ Age _____ Sex: M / F

Emergency Contact_______________________________Relation_______________Home Phone___________________

Work Phone______________________ Cell Phone________________________

Driver's License Number_______________________________

Area to be treated_________________________Date of injury or start of current problem _______________________

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_______________________ Is an attorney involved? Yes / No

Attorney name ____

Address ____ Telephone # (______) _______________

Who is your Primary care provider?____

Name of Provider who referred you (if applicable)____

Patient Signature:____**Date:**_____________________

(OFFICE USE ONLY) 12/12/17

Primary Insurance____

Insured Name_______________________________________Social Sec#__________________________D.O.B.__________

Relation to Patient Spouse / Child / Other

Secondary Insurance____

Insured Name_______________________________________Social Sec#__________________________D.O.B.__________

Relation to Patient Spouse / Child / Other

Referring Dr. Address ____ UPIN # ________________________

Area(s) Being Treated:____

Financial Class: CASH COMMERCIAL INSURANCE MC LIEN W/C

Name: ___________________________Date of first onset/injury ____________________

Check which of the following apply to the nature of your visit: ☐ Work related injury
☐ Recurrence of prior injury ☐ Injury related to falling ☐ Motor vehicle accident
☐ Injury related to lifting ☐ Athletic /recreation ☐Other:__________________
Any other treatments for this? Y N From whom?_________________________________
Any Medical tests for this condition?____
Have you had a surgery for this condition? ☐ No ☐ Yes (dates):____________________
Occupation:_____________________ recreation & exercise routines:_________________
Allergies (include drug):____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ **fever/chills/sweats**
- ❑ **dizziness/lightheaded**
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ **numbness or tingling**
- ❑ muscle weakness
- ❑ **shortness of breath**
- ❑ **fainting**
- ❑ cough
- ❑ **Change headache**
- ❑ nausea/vomiting
- ❑ **weight loss/gain> 10#**
- ❑ Falls/Balance trouble
- ❑ **changes in bowel/ bladder**

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ **cancer**
- ❑ heart problems
- ❑ chest pain/angina
- ❑ osteoporosis/osteopenia
- ❑ circulation problems
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ anemia
- ❑ **bone or joint infection**
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ high blood pressure
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ bladder infection
- ❑ kidney infection
- ❑ STD/HIV
- ❑ thyroid problems
- ❑ **diabetes**
- ❑ asthma
- ❑ multiple sclerosis
- ❑ Lyme's Disease
- ❑ **blood clots**
- ❑ ulcers
- ❑ hepatitis
- ❑ AODA related problem

During the past month have you been feeling down, depressed or hopeless? **YES** **NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **Y N**

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ aneurism

Please list medications currently used (INCLUDING vitamins, and supplements)

1. ______________________ 2.___________________________ 3.______________________________
4. ______________________ 5. __________________________ 6._____________________________

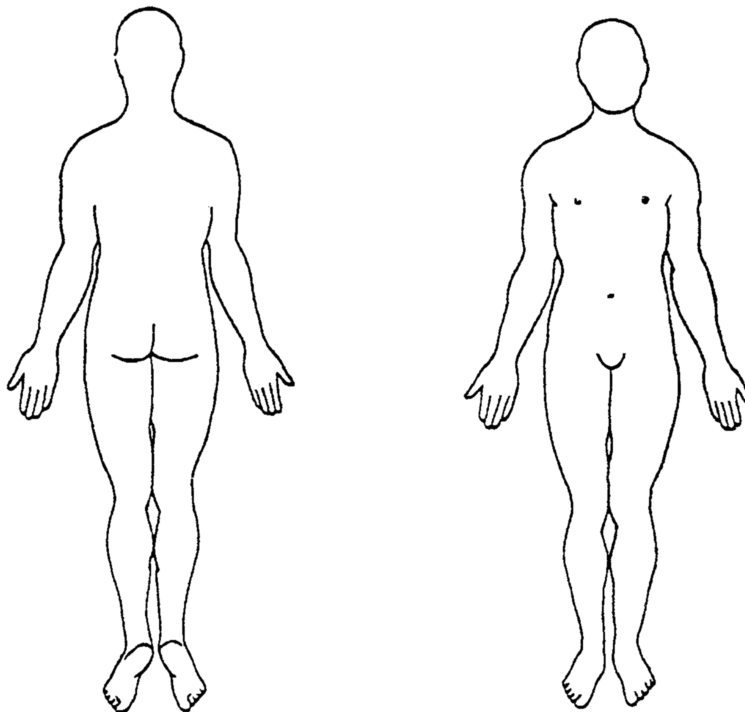
Have you ever taken steroid medications for any medical conditions? **YES** **NO**
Have you ever used blood thinning or anticoagulant medications? **YES** **NO**

Please all surgeries with dates (even ones that don't seem to relate to this issue)

1. ________________________ 2.______________________ 3. _________________________
4. ________________________ 5. ______________________ 6.__________________________

Please mark the areas where you feel symptoms on the chart to the right.

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



For the therapist
+/ - Cough/Sneeze
+/ - Saddle Anesth.
+/ - Bwl/Blddr Chnge
+/ - Numb/Ting.

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"*

Your current level of pain at this moment:______________________________
The best your pain has been during the past 24 hours: ______________________
The worst your pain has been during the past 24 hours: ______________________

My symptoms: ❑ Come & go ❑ Are Constant ❑ Constant, but change with activity
My condition is generally: ❑ Getting Better ❑ Getting Worse ❑ Staying the same

What positions and activities increase your symptoms?______________________
What positions or activities decrease your symptoms?______________________

How is sleep affected? ❑ No problem sleeping ❑ Difficulty falling asleep (minutes to fall asleep?_________) ❑ Awakened by pain (how many times a night_____) ❑ Sleep medication or supplement (item & dosage___________________________)

When are symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night
When are symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)____
2)____
3)____

Therapist use only:

Rating: _______
Rating: _______
Rating: _______
Average: _______