New Patient Form

First Name:	**Last Name:**	Middle Initial:
Home Address:		
City:	**State:**	**Zip Code:**
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Social Security: - -	**Birthday:** / /	
Emergency Contact:	Relation:	Phone Number:
Referring Physician:	**Primary Physician:**	
Primary Insurance Company:	**Primary Insurer's Name:**	
SS# of Primary Insurer: - -	**Insurer's Birthday:** / /	
Secondary Insurance Company:	Secondary Insurer's Name:	
SS# of Primary Insurer: - -	Insurer's Birthday: / /	
Employment: Full-time Part – time (please circle) Not Working Retired	Student: Middle/High School College (please circle) Full-time Part-time	
Marital Status: (please circle) Single Married Divorced Separated Widowed		

Do you have a follow up appointment with your referring physician?
Yes:_______(Date)_______________ No:__________

Please list all of your medications (if you have a medication list, please give it to the receptionist):
____

Please list any recent or major surgeries with dates:
1.____
2.____

Is there a possibility you are pregnant? Yes No

Have you ever had any imaging performed?

X-Ray: ______ MRI: ______ CT Scan: _______ Doppler: ______ Ultrasound: _________

Do you know the results? ____

Please Circle all of the following conditions that pertain to you now or in the past:

Anxiety / Depression	Arthritis	Asthma	Cancer	Chest Pain/Heart Attack
Circulatory Problems	Dizziness/Fainting	Epilepsy/Seizures	Hearing Loss	Heart Disease
High Blood Pressure	Lung Disease	Stroke	Thyroid Problems	

Use of Alcohol/Drugs: ____1-3x/week ____3-7x/week ____7-12x/week ____12+/week

Allergies (please list): ____

Do you currently have or have you had in the past any of the following?

Osteoporosis / Osteopenia: Yes No Cardiac/Heart Problems: Yes No

Cancer: Yes No (if yes, type) ______________________________ Pacemaker/Defibrillator: Yes No

Any unexplained night pain: Yes No Any unexplained weight loss: Yes No

Have you fallen more than once in the past year? Yes No How many times? ___________________

Have you had any other healthcare treatments related to your injury?

Physical Therapy: _______ Chiropractics: ________ Injections: ________ Massage: _______ Acupuncture: _______

Date of Injury or Onset of Symptoms: ___________________ Cause of injury (if known): ________________________________

When is your pain most aggravating?
Morning: _____ Evening: ______ Constant:______

When is your pain least aggravating?
Morning: _____ Evening: ______ Constant:______

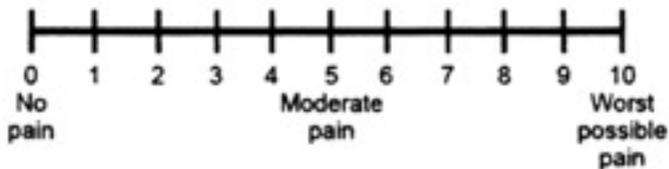
What makes your pain worse?

____

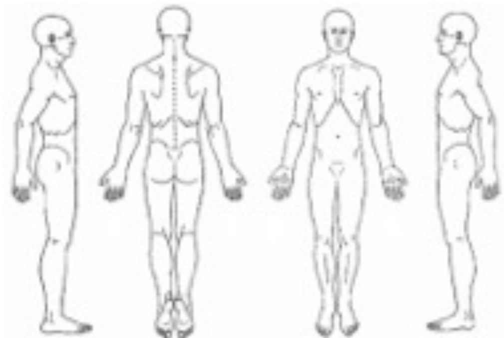
What makes your pain better?

____

On a scale of **0 - 10**, *0* meaning *no pain*, and *10* meaning *you should be in the Emergency Room*, please circle the number that best describes your symptoms:



Location of symptoms: please indicate on diagram
000=Numb/tingling XXX=Sharp Pain
- - - =Burning +++ = Aching



I understand that I am responsible to inform the physical therapist of any health problems and allergies that I have, as well as any drugs or medications I am taking. I verify all of the provided information is accurate.

Patient Signature: ____ Date: _________________________