Todays Date:

Patient Information

Name _____ Date of Birth _____ Sex ◯M ◯F

Street Address _____ City/State _____ Zip _____

Social Security # _____ Status ◯Single ◯Married ◯Other

Cell Phone _____ Home Phone _____

Work Phone _____

Best Number to Call ◯Cell ◯Home ◯Work

Email Address _____ ☐No Email ☐Decline Email

Appointment Reminder Contact Method? ☐ Text ☐ Email ☐ No Appointment Reminder

Emergency Contact Information

Contact Name _____ Phone _____ Relationship _____

Employment Status FT PT None Retired Student

Employer _____ Occupation _____

Primary Care Doctor _____ Referring Provider (if different) _____

May we send your doctor your physical therapy evaluation? ◯ Yes ◯ No

How did you hear about our office?

◯My Doctor _____ ◯Family/Friend_____

◯Internet ◯Walk/Drive by ◯Other_____

Insurance Information

Primary Insurance

Insurance/Plan _____

Policy ID # _____ Group # _____

Are you the policy holder? ◯Yes ◯No If no, please provide policy holder information.

Policy Holder Name _____ Date of Birth _____ Relationship to Patient _____

Secondary Insurance

Insurance/Plan _____

Policy ID # _____ Group # _____

Are you the policy holder? ◯Yes ◯No If no, please provide policy holder information.

Policy Holder Name _____ Date of Birth _____ Relationship to Patient _____

Medical History

Patient Name _____ Height ____ ft ____ in Weight _____ lbs

Primary Concern or Symptoms _____

How did this injury/exacerbation occur? _____

Where did this injury occur? ◯ Home ◯ Work ◯ Automobile ◯ Sports

Approximate Date of Onset _____

Are your symptoms currently ◯ Getting Better ◯ Same ◯ Constant ◯ Worse

What is your current pain level, on a scale of 0-10? (0 - No Pain, 10 - Worst Pain)

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Have you had any of the following? ☐ X-Ray ☐ MRI ☐ CT Scan

If Yes, results_____

Have you seen another doctor for this problem? ☐ Yes ☐ No If Yes, who _____

Have you had this problem or symptoms in the past? ☐ Yes ☐ No

Have you been hospitalized for this condition? ☐ Yes ☐ No If Yes, date _____

Have you had surgery for this condition? ☐ Yes ☐ No If Yes, date _____

If Yes, surgery type _____

Have you had any other treatments for this? ☐ Yes ☐ No If Yes, explain_____

Please list all medications you are taking (prescription, over the counter and vitamin):

_____

Please list any allergies (drug, chemical, latex, iodine) _____

Do you consume alcohol? ☐ Yes ☐ No If Yes, frequency _____

Do you use tobacco? ☐ Yes ☐ No If Yes, frequency_____

Please check each condition you have been told you have/had?

☐ Tuberculosis	☐ Type 1 Diabetes	☐ Heart Condition
☐ Cancer	☐ Type 2 Diabetes	☐ Epilepsy
☐ Arthritis	☐ Stroke	☐ Respiratory Problems
☐ Pacemaker	☐ Dementia	☐ High Blood Pressure
☐ Osteoporosis	☐ Osteopenia	☐ Liver Disease
☐ Fibromyalgia	☐ Hepatitis	☐ Incontinence

Do you have any other conditions ☐ Yes ☐ No If Yes, please explain_____

_____

Are you interested in a complimentary consultation to learn how Regenerative Medicine can help you?

◯ Yes ◯ No

Are you interested in custom orthotics?

◯ Yes ◯ No

Current Condition

Primary Complaint _____

What increases your pain? _____

What decreases your pain? _____

Describe when your symptoms occur (check all that apply)

☐ Constant ☐ Intermittent ☐ Chronic ☐ With Activity ☐ Upon Waking

Describe your pain (check all that apply)

☐ Sharp ☐ Stabbing ☐ Aching ☐ Burning

☐ Numbness ☐ Pins & Needles

What activities are you restricted from by your condition? (check all that apply)

☐ Dressing ☐ Walking ☐ Pushing ☐ Bathing

☐ Lifting ☐ Pulling ☐ Eating ☐ Work

☐ School ☐ Driving ☐ Standing ☐ Sleeping

☐ Housewotk ☐ Lying Down ☐ Sport ☐ Sitting

What do you want to achieve from having therapy? (check all that apply)

☐ Improve home activities ☐ Improve leisure/sport activities ☐ Improve self care activities

☐ Improve mobility/walking activities ☐ Improve health/wellness ☐ Return to work

Please answer the following questions required by your insurance company.

Do you use any assistive devices? ◯ Yes ◯ No If Yes, explain _____

How many story(s) is your home? ☐ 1 ☐ 2 ☐ 3 ☐ Other _____

How many step(s) or stair(s) does your home have? _____

Does your house have handrail(s)? ☐ N/A ☐ Left ☐ Right ☐ Both Sides

Please list anyone that lives in the same home as you. _____

What is your goal for therapy?

_____