NEW PATIENT INFORMATION

Name____Date________________
Address____
Phone (Home)________________ Work________________ Cell____________
D.O.B.__________ S.S.#_____-_____-_____Referring M.D.______________
Emergency or alternate contact name and number____________________
Employer________________________ Position________________
Work Address____
Is your injury work related or brought on by another type of accident? (If yes please explain briefly)____

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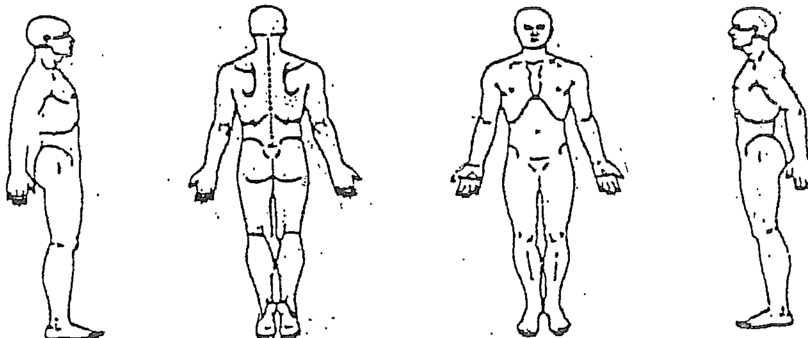
1. Please describe your Current Complaint or Limitation:________________
____
____
2. What is your goal for therapy?_____________________________
____
3. Please describe the nature of your pain:
   - ☐ Sharp Pain
   - ☐ Dull (Pain) Ache
   - ☐ Throbbing
   - ☐ Shooting
   - ☐ Burning
   - ☐ Tingling
   - ☐ Numbness
   - ☐ Constant (76-100%)
   - ☐ Frequent (51-75%)
   - ☐ Occasional (26-50%)
   - ☐ Intermittent (25% or less)

⇒⇒⇒MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



4. Indicate the intensity of your pain at rest: 0 1 2 3 4 5 6 7 8 9 10
5. Indicate the intensity of your pain with movement: 0 1 2 3 4 5 6 7 8 9 10
6. What movement causes the pain to increase?______________________
7. Since this condition began, your symptoms have ☐decreased ☐not changed ☐increased
8. Your symptoms are WORST in: ☐morning ☐afternoon ☐night ☐increased during the day ☐same all day
9. Your symptoms are BEST in: ☐morning ☐afternoon ☐night
10. When did your problem begin? ___days ago ___months ago___years ago (Date _______)
11. Describe how your problem began:_____________________________
12. Did you have Surgery? ☐Yes ☐No **Date of Surgery**__________**Facility**___________
13. In the past, have you been treated for this problem? ☐Yes ☐No
    If so, who did you see for that condition? ☐MD ☐Physical Therapist
    ☐Occupational Therapist ☐Chiropractor ☐Other________________

14. What makes your problem BETTER? ☐Nothing ☐Lying Down ☐Standing ☐Sitting
☐Movement/Exercise ☐Inactivity

15. What makes your problem WORSE? ☐Nothing ☐Lying Down ☐Standing ☐Sitting
☐Movement/Exercise ☐Inactivity

16. Occupation________________________ ☐F/T ☐P/T

17. Has your work status changed because of this condition? ☐Yes ☐No

18. What is your current work status? ☐F/T, no restrictions ☐F/T, with restrictions
☐P/T, no restrictions ☐P/T, with restrictions ☐Retired ☐Unemployed
☐F/T Homemaker ☐F/T Student ☐Off due to medical reasons

19. Do you have a permanent disability rating? ☐Yes ☐No
If yes, Location__________ Date Received __________ Rating Percentage____%

20. Date you last saw your Physician: ______________________

Sporting Interests/Activities:______________________________

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Please check all boxes that apply:

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer- Location:______________ Date:______
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Raynauds
☐	☐	Pregnancy
☐	☐	Other______________
☐	☐	Tobacco-packs/day________
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeine drinks: cups/cans per day________
☐	☐	Allergies:______________

Hospitalization/Surgical Procedures (list if not described elsewhere):______________

____

Medications:______________________________

Present: Weight__________ Height__________

MD Follow-up Visits:______/______/______/______/______/______/______/______

Patient's Signature:______________________ Date:______________