PATIENT INFORMATION

Patient Name ______________________________________ DOB: ___________ Date: _________
First M.I. Last

Email ____ Phone: ______________________

Address _________________________________City_____________ State_____ Zip:_________

Social Security #__________________________ Drivers License # _____________________

Occupation: ________________ □Full time □Part Time □Retired □Other Employer: ____________

Gender: □M □F □Prefer not to specify Marital Status: □Single □Married □Divorced □Widowed

Emergency Contact / Alternative Contact: _______________ _______________ ____________
Name Phone Relationship

Appointment reminders: □Email □Text □none Who may we thank for referring you? ____________

PRIVATE INSURANCE

Do you have Insurance? □Yes □No □see scanned card

If yes - Primary Insurance Name_____________________________ Phone_________________

ID#_____________________________________ Group #_________________________________

If applicable:

Secondary Insurance Name_________________________________ Phone_________________

ID#_____________________________________ Group #_________________________________

RESPONSIBLE PARTY

□ Self (if self, go to next section) □Parent □Spouse □Other (define)______________________

Responsible Party's Name______________________ Date of Birth________ Phone_____________

Address_______________________________City____________State____ Zip Code____________

Social Security #____

Employer___________________________________ Work Phone_________________________

ACCIDENT INFORMATION

Motor Vehicle Accident? □Yes □No Date of Accident ______________

Adjustor__________________________ Claim #_____________________ Phone_____________

Work Related Injury? □Yes □No Date of Accident ______________

Adjustor__________________________ Claim #_____________________ Phone_____________

Attorney Involved? □Yes □No Date of Accident ______________

Adjustor__________________________ Claim #_____________________ Phone_____________

MEDICAL INFORMATION

Have you ever had any of the following? (Please check ALL that apply)

□ Allergies
□ Asthma / difficulty breathing
□ Cancer
□ Depression / Anxiety
□ Diabetes or hypo/hyperglycemia
□ Dizziness / Vertigo
□ Fracture or Suspected Fracture
□ Headaches / injury to head
□ Heart condition / pacemaker
□ High / low blood pressure
□ Lung disorders

□ Mental condition
□ Multiple Sclerosis
□ Night pain
□ Osteoporosis
□ Osteoarthritis or Rheumatoid arthritis
□ Parkinson's
□ Stroke
□ Swelling / joint pain
□ Vision / hearing problems
□ Surgeries: ___________________________________
□ Other: ______________________________________

Use of tobacco? □ Yes □ No □ In the past

Are you currently pregnant? □ Yes □ No

Any recent unexplained weight loss? □ Yes □ No

Falls in past year? □ Yes □ No How many: _______

CURRENT CONDITION

What are you being treated for? ____

When did it start? _____________ How did it happen? ______________________________________

What makes it better? _______________________ What makes it worse? _________________________

Imaging: □ MRI □ X-Ray □ Other Date / Office: ____

Previous or recent surgery for this issue (type, date): ____

Have you noticed in recent changes in: □ Bowel/bladder □ Weakness □ Numbness

Any other pertinent information? ____

____

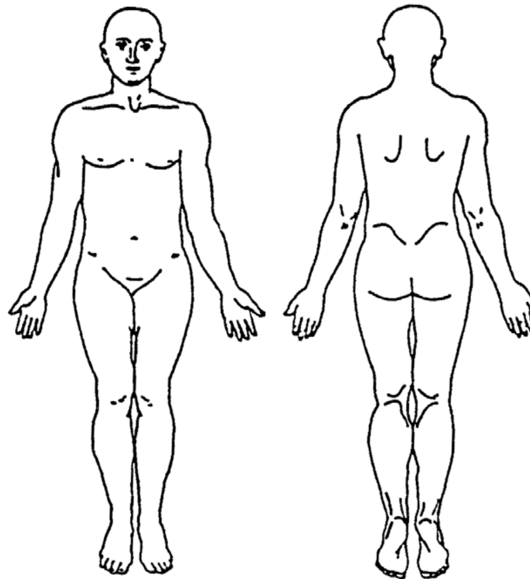
RANGE
PHYSICAL THERAPY + WELLNESS

MEDICATION LIST

MEDICATION	DOSE / FREQUENCY	REASON

Please use the diagram below to indicate the symptoms you are experiencing.

A: ache S: stabbing R: radiating P: pins and needles N: numbness O: other



Please circle the severity of your pain, 0 (being no pain) 10 (being severe pain)

Current Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10
Worst Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10
Least Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10

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