PATIENT (LEGAL) NAME:_____ SEX:_____ BIRTHDATE:_____

PREVIOUS/MAIDEN NAME(s): _____ SSN:_____

PHYSICAL ADDRESS:_____
City State Zip

MAILING ADDRESS:_____
City State Zip

PHONE: HOME/CELL:_____ EMAIL: _____

EMPLOYER:_____ PHONE:_____

SPOUSE NAME:_____ SPOUSE DOB:_____ PHONE:_____

EMERGENCY CONTACT (OUTSIDE OF HOME):_____ PHONE:_____

HOW DID YOU HEAR ABOUT US? _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A COVERED DEPENDENT

(**Please note**: *If you are over 18, but covered by your parent(s) insurance plan, we can bill your parent(s) for you as a courtesy. Please understand you are ultimately responsible for any unpaid balances on your account.)(If you do fill this section out-this shall also serve as a release to communicate with said individuals regarding your account balance.)*

MOTHER'S INFORMATION:

NAME: _____ DOB:_____ PHONE:_____

ADDRESS:_____ EMPLOYER:_____ WORK PHONE:_____

FATHER'S INFORMATION:

NAME: _____ DOB:_____ PHONE:_____

ADDRESS:_____ EMPLOYER:_____ WORK PHONE:_____

INSURANCE INFORMATION

PRIMARY:
POLICYHOLDER NAME:_____ DOB:_____ RELATION:_____

INSURANCE COMPANY:_____ ID/CLAIM #:_____GROUP #:_____

SECONDARY:
POLICYHOLDER NAME:_____ DOB:_____ RELATION:_____

INSURANCE COMPANY:_____ ID/CLAIM #:_____GROUP #:_____

_____ _____
SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR) DATE

NAME: _____ DATE: _____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: _____

2. HOW ACTIVE IS YOUR LIFESTYLE? _____ SEDENTARY ____ MODERATE PHYSICAL ACTIVITY _____ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING?_____
DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

_____

_____

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT:_____

_____

B. **PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.**

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

_____ CONSTANT
_____ COMES AND GOES AT REGULAR TIMES
_____ HAPPENS ONCE IN A WHILE

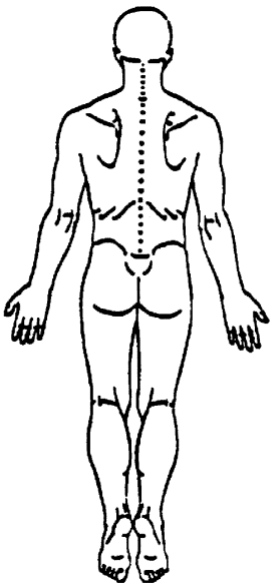
RELATIONSHIP OF SYMPTOMS TO SLEEP:

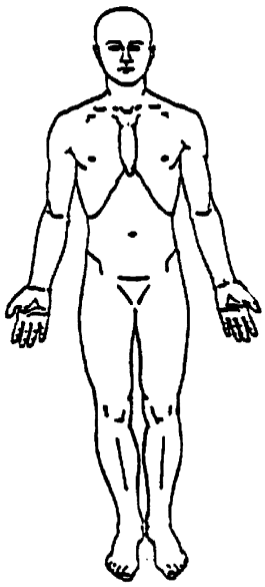
_____ WAKES FROM SLEEP
_____ PREVENTS SLEEP
_____ BETTER AFTER SLEEP

SYMPTOM SCALE- 0 BEING NONE AT ALL 10 BEING AS BAD AS IT CAN BE

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness





PATIENT SIGNATURE:
_____ DATE:_____

NAME:_____ DATE:_____

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ ALZHEIMER'S	_____ HIGH BLOOD PRESSURE	_____ OSTEOARTHRITIS
_____ CARDIOVASCULAR DISEASE	_____ HISTORY OF CANCER	_____ PARKINSON'S
_____ CURRENT INFECTION	_____ HUNTINGTON'S	_____ PREGNANT/POSSIBLY PREGNANT
_____ CVA/STROKE	_____ LUPUS	_____ RHEUMATOID ARTHRITIS
_____ DIABETES TYPE 1/TYPE 2 (CIRCLE)	_____ MUSCULAR DYSTROPHY	_____ TRAUMATIC BRAIN INJURY
_____ FIBROMYALGIA	_____ HIV, HEPATITIS B, HEPATITIS C	

_____ PREVIOUS FRACTURED BONES (IF SO WHICH ONES):_____

SURGICAL HISTORY:_____

OTHER: _____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_____ DATE:_____

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_____ DATE:_____

Medicare Required Questions

Name:_____ Date:_____

Have you been in the hospital for this condition in the past 30 days? (Please circle one)

Yes No

Have you been in the nursing home/skilled nursing facility or received home health services of any kind for this condition in the past 60 days? (Please circle one)

Yes No

Are you currently seeing any other healthcare providers for this condition? (Please circle any and all that apply)

Medical Doctor
Nurse Practitioner
Chiropractor
Physical Therapist
Occupational Therapist
Speech Therapist
Other:_____

Have you been treated for this condition at this physical therapy facility or a different physical therapy facility in the past? (Please circle one)

Yes No

Since the beginning of this year, have you received treatment for this or a different condition by an occupational, speech, or physical therapist? (Please circle one)

Yes No

Falls:

- Have you fallen in the past year? (Please circle one) Yes No
- How many times?_____
- What were the circumstances that made you fall?_____
  _____
- Did you have an injury from the fall?_____
  _____