Please be sure to fill out all information to ensure proper billing.

Patient Information

Full Name: ____**Home Phone:** ____________________

Address: ____________________________**City:** ____________**State:** ______**Zip Code:**__________

Other Phone:_____________________ **E-Mail Address:**___________________________________

Patient's Employer: ____________________________ **Work Phone:** ________________________

Address: ___________________________ **City:** ____________**State:** _______**ZIP Code:** ________

Date of Birth ___/___/___ **Sex**_____ **Social Security #** ______/____/_____ **Marital Status** _______

Race: _____________ **Primary Care Doctor:** ______________ **Referring Doctor:** ___________

Responsible Party (Card holder information)

Full Name: ____**Home Phone:** ____________________

Address: ____________________________**City:** ____________**State:** ______**Zip Code:**__________

Employer: ____**Work Phone:** _____________________

Address: ___________________________ **City:** ____________**State:** _______**ZIP Code:** ________

Date of Birth ___/___/___ **Sex**_____ **Social Security #** ______/____/_____ **Marital Status** _______

Relation to Patient: ____

Emergency Contact

Full Name: _________________________________ **Home Phone:** ___________________________

Address: ____________________________**City:** ____________**State:** ______**Zip Code:**__________

Work Phone: ____________________________ **Cell Phone:** _____________________________

Relation to Patient: _______________________ **Marital Status:** __________________________

Insurance Information

Primary Insurance: _____________________________________**Effective Date:** _______________

Identification #: ________________________________ **Group #:** ___________________________

If you have multiple insurances, please add them to the back of this page.
Thank you.

PATIENT MEDICAL HISTORY

Name: ___________________________________

Physician:________________________________
Type of surgery/Date:_____________________
Prior surgery for this condition: YES NO

Accident/Injury Information

How were you injured: Work Related:____ Car Accident:____ (state accident occurred ____) Sports Injury:____ Other:____
Description of Accident/Injury:____
Date of injury or onset of symptoms/problems:____

Are You Currently Taking ANY Prescription or Non-Prescription Medications? YES NO

Anti-inflammatories	_______	**List Medications**	____ **Separate list attached**
Muscle Relaxants	_______	______________________________	
Pain Medications	_______	______________________________	
Antibiotics/Other	_______	______________________________	

Have you had any of the following Medical or Rehabilitative Services for THIS Injury/Episode?

	YES	**NO**		**YES**	**NO**
Physical/Occupational Therapy	___	___	MRI	___	___
Chiropractor	___	___	CT Scan	___	___
Massage Therapy	___	___	X-Ray	___	___
Emergency Room Care	___	___	Specialist Care	___	___

Other:____

Do you NOW HAVE or HAVE YOU EVER HAD ANY of the following?

	YES	**NO**		**YES**	**NO**
Asthma, Bronchitis, or Emphysema	___	___	Severe/Frequent Headaches	___	___
Diabetes	___	___	Vision/Hearing Difficulties	___	___
LATEX Allergy	___	___	Numbness/Tingling	___	___
Shortness of Breath/Chest Pain	___	___	Dizziness or Fainting	___	___
Coronary Heart Disease/Angina	___	___	Ringing in Ears	___	___
Do you have a Pacemaker	___	___	Weakness	___	___
High Blood Pressure	___	___	Weight Loss/Energy Loss	___	___
Stroke/TIA	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Pins or Metal Implants	___	___
Epilepsy/Seizures	___	___	Joint Replacement	___	___
Anemia	___	___	Neck Injury/Surgery	___	___
Infectious Disease	___	___	Shoulder Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Elbow-Wrist-Hand Injury/Surgery	___	___
Arthritis (RA/OA)	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Hip-Knee Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Leg-Ankle-Foot Injury/Surgery	___	___
Bowel/Bladder Problems	___	___	Do You Smoke	___	___

Do you have any allergies (Please List):____

Please list your main goals for attending therapy:____
I Prefer Receiving My Home Instructions: ☐ **In written form** ☐ **In picture form** ☐ **Hands on practice**

PLEASE RATE YOUR PAIN ON A SCALE OF 0 (NO PAIN) TO 10 (WORST IMAGINABLE PAIN):

0 1 2 3 4 5 6 7 8 9 10