

New Patient Information

Please print clearly

Date: ____/____/____

Patient Name: _____ Sex: Male Female
Last First M.I.

Address: _____
Street City State Zip

Parent or Guardian (if patient is a minor): _____

Is patient employed? Yes No Full-time student Occupation: _____

Employer or School: _____ Marital Status: Married Single Other

Home Phone: (____) ____-____ Work Phone: (____) ____-____ ext. ____

E-mail: _____

Date of Birth: ____/____/____ SS#: ____-____-____

Referring Dr.: _____
Name Address Phone

Primary Care Dr.: _____

How did you hear about our office? _____

EMERGENCY CONTACT (not living with patient): _____

Phone: (____) ____-____ Relationship: _____

Insurance Information:

Primary Insurance Co: _____

Group #: _____ Policy I.D./Claim #.: _____

Is patient the subscriber? Yes No If no, then:

Subscriber's Name: _____ Subscriber's Employer: _____

Relationship to Patient: _____ Subscriber Date of Birth: ____/____/____

In Order to Bill Your Insurance, We Must Have a Copy of Your Insurance Card.

Injury Information:

Condition is related to: Work Auto Home Sports Other None

Date of injury/onset of condition: ____/____/____

Body side: Right Left Both Body part affected: _____

Vocational Rehab Counselor or Claims Manager or Attorney:

Name: _____ Phone (____) ____-____

E-mail: _____ Fax (____) ____-____

Address: _____
Street City State Zip

For Office Therapist: _____ Core Number: _____
 Use Only Dx Codes: _____

Core Physical Therapy, PC

Patient Name: _____

Date: _____

Date of onset: _____

Surgeries Performed, including date: _____

Do you smoke: Yes No

Any History of Falls: Yes No If Yes when was your last fall: _____

Mechanism of Injury (How did injury occur):

*Did you require assistance/help with any of the following before the onset of your symptoms?
Please mark all that apply.*

Activities of daily living/ daily activities <input type="checkbox"/> Self care <input type="checkbox"/> Work/vocation <input type="checkbox"/>	Care giving <input type="checkbox"/> Mobility/ambulation/walking <input type="checkbox"/> Activities outside your home/travel <input type="checkbox"/>
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Since the onset of your symptoms, do you have any pain or difficulties with the following?

Sleep <input type="checkbox"/> Self care <input type="checkbox"/> Activities of daily living/ daily activities <input type="checkbox"/> Reaching/pushing/pulling <input type="checkbox"/> Lifting/carrying <input type="checkbox"/>	Sitting/standing <input type="checkbox"/> Bending/squatting <input type="checkbox"/> Mobility/ambulation/walking <input type="checkbox"/> Activities outside your home/travel <input type="checkbox"/> Other: _____ <input type="checkbox"/>
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Which of the following make your pain worse?

Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Stairs - up <input type="checkbox"/> Stairs - down <input type="checkbox"/> Lifting/Carrying/Reaching <input type="checkbox"/>	Sit to stand <input type="checkbox"/> Bending <input type="checkbox"/> Laying <input type="checkbox"/> Cough/sneeze <input type="checkbox"/> Pushing/Pulling <input type="checkbox"/> Other: _____ <input type="checkbox"/>
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Primary concern: _____

<i>Pain scale</i>	0	1	2	3	4	5	6	7	8	9	10
<i>Mark the dots:</i>	<i>No pain</i>					<i>Moderate</i>					<i>Severe</i>
At worst <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At best <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Name: _____

Date: _____

Since the onset of your symptoms are you getting: Better Worse No Change

Pain description:

Burning <input type="checkbox"/>	Shooting <input type="checkbox"/>	Worse in AM <input type="checkbox"/>
Sharp <input type="checkbox"/>	Tingling/Numbness <input type="checkbox"/>	Worse in PM <input type="checkbox"/>
Dull/Ache <input type="checkbox"/>	Constant <input type="checkbox"/>	Other: _____ <input type="checkbox"/>
Throbbing <input type="checkbox"/>	Intermittent <input type="checkbox"/>	

Pain location: _____

Medical History:

No known previous medical history <input type="checkbox"/>	Diabetes Mellitus type 1 <input type="checkbox"/>	Previous therapy <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Diabetes Mellitus type 2 <input type="checkbox"/>	Psycho-Social <input type="checkbox"/>
Cardiovascular disease <input type="checkbox"/>	Allergies <input type="checkbox"/>	Night pain <input type="checkbox"/>
Unexplained weight loss <input type="checkbox"/>	Surgical history <input type="checkbox"/>	Cancer <input type="checkbox"/>
Bowel/Bladder changes <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Seizures <input type="checkbox"/>
Immune Deficiency disease <input type="checkbox"/>	Dizzy spells <input type="checkbox"/>	Other <input type="checkbox"/>

Please describe:

Diagnostic testing:

X-ray <input type="checkbox"/>	PET Scan <input type="checkbox"/>	Angiogram <input type="checkbox"/>
CT Scan <input type="checkbox"/>	Ultrasound <input type="checkbox"/>	Cardiac Stress Test <input type="checkbox"/>
MRI <input type="checkbox"/>	Venous Duplex <input type="checkbox"/>	ECG <input type="checkbox"/>
EMG <input type="checkbox"/>	Holter Monitor <input type="checkbox"/>	Other <input type="checkbox"/>

Specific findings/Results: _____

What makes your pain better: _____

Current medications:

What would you like to accomplish through physical therapy? ie.Goals:
