

NEW PATIENT INFORMATION

Name: _____ Date: _____

If patient is under 18 yrs old - Guardian or Guarantor: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN#: _____ Birth date: _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Phone #: (____) _____ Work #: (____) _____ Cell #: (____) _____

EMAIL ADDRESS: _____

Referring Physician: _____ Date last seen: _____

Employer: _____ Address: _____

Emergency Contact: _____ Phone # (____) _____

Have you received PT or Chiropractic care this year? Yes No Where? _____

How did you choose Woodford Physical Therapy? Doctor Friend Self choice Advertisement

Name of Person who referred you: _____

Primary Care Physician: _____

I request that payment from my insurance carrier be made to me or on my behalf to "Woodford PT" for any services furnished to me by Woodford PT. I understand my signature, requests that payment be made and authorizes release of medical information necessary to pay all claims for services rendered. I authorize any treatment performed by Woodford PT.

Please Sign: _____ **Date:** _____

The following questions are being asked to fulfill our commitment to protect your privacy (please check all boxes that apply):

1. Is there anyone other than you that we can discuss your medical information? Yes No

Name: _____

2. How may we contact you to confirm appointments?

Which do you prefer? Phone (Call) Phone (Text) Email

3. If you are unavailable may we leave a message in voicemail or with person answering the phone?

Yes No **(If we have permission to leave a message we will identify ourselves as well as what office we are from.)**

4. Upon request may we fax your health and billing information? Yes No

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____, have received the Notice of Privacy Practices from Woodford PT.

Please Sign: _____ **Date:** _____

Medical History: Please check box if you have any of the following medical conditions:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vision Problems |

Describe any other conditions or precautions:

Fall History:

Have you had an injury as a result of a fall in the past year? Yes No
Two or more falls in the last year? Yes No

Surgical History:

Body Region(s): _____
Surgery Type(s): _____
Approximate Date(s): _____

Medications: Please specify drug, dosage, and reason taking

Drug or Substance Allergies: _____

Social History and Living Conditions:

Marital Status: Single Married Separated Divorced Widowed
Tobacco Use: Never Quit/When? _____ Current Smoker/packs per day? _____
Alcohol Use: Never Rarely Moderate Daily
Drug Use: Never Type and frequency: _____
House: Single story Multiple levels
Steps: Steps to enter house/work Steps in house/work Approximate number? _____
Drive Car: Never Rarely Daily
Living arrangement: Live with someone Live alone

History of Present Injury/Illness:

Please explain your current problem: _____

Where is your problem located? Right Left Both Specify Location: _____

When did your problem start? _____

How did it start? _____

Was it work related? Yes No Do you have pain? Yes No

Severity: (0 = no pain 10 = worst imaginable pain): _____

What kind of pain? Throbbing Sharp Radiating Dull Ache Soreness Burning Tingling

When? Sudden Constant Comes and goes With movement only Sleep

What makes it worse? Walking Running Standing Getting up Stairs Sitting
 Gripping Reaching overhead

What else do you experience? Swelling Grinding Giving way Catching Popping
 Locking Sleeping Problems

Does the condition affect ability to work? Yes No

How? _____

Occupation: _____ Medical Leave Light Duty Full Duty

Does it affect your everyday living/sports/hobbies? Yes No

How? _____

Have you previously had this or a similar problem? Yes No

Did you improve? Yes No

Why do you think? _____

What previous treatments or surgery have you received for this problem? _____

Have you previously seen someone for this current problem? MD Chiropractor PT/OT

Who? _____

Have you had any of the following? X-ray MRI Bone Scan CT

When? _____ Where? _____

Do you have copies or reports? Yes No

Patient Statement:

To the best of my knowledge, the above information is accurate and complete.

Please print your name: _____

Signature (Parent/Guardian): _____