

**NEW PATIENT INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

**WOULD YOU LIKE TO RECEIVE APPT NOTIFICATIONS BY EMAIL OR TEXT?**

**CIRCLE ONE: NO THANKS    EMAIL    TEXT (put cell # above-text message charges may apply)**

**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 Pro-Active Therapy?  Doctor  Friend  Self choice  Advertisement

Name of person who referred you: \_\_\_\_\_

I request that payment from my insurance carrier be made to me or on my behalf to "ProActive Therapy" for any services furnished to me by ProActive Therapy. 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 ProActive Therapy.

**Please sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Guardian signature if patient under 18: \_\_\_\_\_

**Primary Responsible Party, please check box**

Health Insurance: Name of insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Workers Comp: Name of Insurance: \_\_\_\_\_ Employer: \_\_\_\_\_

Auto accident: Name of Insurance: \_\_\_\_\_

Self pay

**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. May we contact you by phone to confirm appointments, and/or billing information?

Which do you prefer  Home Phone  Work Phone  Cell Phone

3. If you are unavailable at work may we leave a message in voice mail 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 ProActive Therapy. 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:**

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**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**

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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): \_\_\_\_\_