

**NEW PATIENT INFORMATION**

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

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

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

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ 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 Pro-Active Therapy?  Doctor  Friend  Self choice  Advertisement

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: \_\_\_\_\_

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

Primary Responsible Party, please check box

Health Insurance (please present card at time of service)

Name of policy holder: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Workers' Compensation, Employer (if different from above) \_\_\_\_\_

Contact person \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Auto accident no fault health insurance carrier \_\_\_\_\_

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 Reciept of Notice of Privacy Practices I, \_\_\_\_\_, have received the Notice of Privacy Practices from ProActive Therapy. Sign: \_\_\_\_\_ Date \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**MEDICAL HISTORY: Please circle (Y)es or (N)o if you have any of the following medical problems.**

High Blood Pressure: Y N      Diabetes: Y N      Heart Trouble: Y N      Pace Maker: Y N

Respiratory Problems: Y N      Stroke: Y N      Bleeding Problems: Y N      Cancer: Y N

Other: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Drug Allergies or Substance Allergies:  Yes  No

List: \_\_\_\_\_

Past Hospitalizations/Surgeries/Injuries and Approximate Dates: \_\_\_\_\_

**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  All the time  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 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  X-ray  MRI  Bone Scan  CT

When \_\_\_\_\_ Where \_\_\_\_\_ Do you have films \_\_\_\_\_ Do you have report \_\_\_\_\_

**Patient Statement:** To the best of my knowledge, the above information is accurate and complete.

Please print your name \_\_\_\_\_ Signature (Parent/Guardian) \_\_\_\_\_

Physical Therapist has reviewed this document with patient. Signed \_\_\_\_\_ Date \_\_\_\_\_