

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 Woodford Physical Therapy? Doctor Friend Self choice Advertisement

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: _____

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