New Patient Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

PATIENT INFORMATION:

Name: _____ Date of birth:_____
(Last) (First) (Middle Initial)

Name of legal guardian if under 18 years old:_____

Address: _____
Street address City State Zip

Home Phone: _____ May we leave a message? _____

Cell Phone: _____ May we leave a message?_____ Would you like a text appt reminder?_____

E-mail:_____ May we email you? _____ (home exercises, health classes)
* Please noted: E-mail correspondence is not considered to be a confidential medium of communication

Gender:_____ Marital Status:_____ Student?_____

Height:_____ Weight:_____

Emergency Contact: _____ Phone:_____

How did you hear about our office?_____

INJURY DETAILS:

Reason for visit:_____
(Body part) (Description)

Date of onset (if over a year, date of most recent flare-up): _____

Is condition related to: automobile accident?_____ work related accident? _____ other? _____

Have you received surgery for this condition? Date:_____ Is this condition related to a fall? _____

INSURANCE:

Primary:_____ ID # _____ Group # _____

Secondary: _____ ID# _____ Group # _____

Tertiary: _____ ID # _____ Group # _____

MEDICAL HISTORY:
Please check all conditions that you are currently experiencing or have experienced in the past

__ anemia	__ pacemaker	__ allergies
__ back pain	__ angina	__ asthma
__ bronchitis	__ blood clot/emboli	__ bowel/bladder issues
__ dizziness	__ coronary heart disease	__ pregnant
__ epilepsy	__ drink alcohol	__ emphysema
__ heart attack	__ gout	__ hearing difficulties
__ kidney disease	__ hernia	__ high blood pressure
__ severe/frequent headaches	__ Parkinson's Disease	__ pneumonia
__ stroke/TA	__ sleeping problems	__ smoke cigarettes
__ vision difficulties	__ thyroid problems	__ varicose veins
__ women's health issues	__ weakness	__ weight/energy loss

DO YOU, OR HAVE YOU HAD PROBLEMS WITH THE FOLLOWING?

Ankles	__ left	__ right	__ both
Elbows	__ left	__ right	__ both
Hips	__ left	__ right	__ both
Knees	__ left	__ right	__ both
Legs	__ left	__ right	__ both
Shoulders	__ left	__ right	__ both
Wrists	__ left	__ right	__ both

PLEASE SELECT ALL THAT APPLIES

__ joint replacement(s)	__ pins or metal implants	__ complex regional pain syndrome
__ diabetes, type 1	__ diabetes, type 2	__ arthritis
__ numb/tingle/neuropathy	__ cancer	__ infectious disease
__ incontinence	__ pelvic floor issues	__ other important issues
__ vertigo/balance issues	__ other surgery	__ I have received home PT
__ I live alone	_ I am a caregiver for someone	__ I use a cane
__ I use a walker	__ I use a wheelchair	__ My home has stairs

Does your current condition impact your ability to do your job?_____

Does your current condition impact your ability to attend school?_____

How often do you exercise? __ never __ 1x per week __ 2x per week __ 3x per week __ 4+ x per week

Does your daily routine or work aggravate your current injury? __ no __ I can't perform my normal activities
__ impacts my injury 1x per week __ 2x per week _ _ 3x per week __ impacts daily

MEDICATIONS

If you have a list of current medications just bring it to your appointment, if not, please complete the following

Name	Dosage	Frequency	

What prompted TODAYS visit?

Ankle R L Both
Arm R L Both
Buttock R L Both
Chest R L
CRPS R L
Elbow R L
Feet/toes R L
Forearm R L
Hands/Fingers R L
Head R L
Hip R L Both
Incontinence
Jaw R L
Knee R L Both
Low Back R L Both
Neck R L Center
Pelvic Floor
Shin/Calf R L Both
Shoulder R L
Spine R L Center
Thigh R L Both
Upper Back R L Both
Vertigo/Balance
Wrist R L Both
Other: _____
_____
_____
_____

Have you every had this problem before? _____

If yes, when?_____

Please circle the best description of your pain

Aching	Dull	Throbbing	Burning	Heavy	Variable
Constant	Numb	Weak	Cramping	Pins/Needles	Deep
Stabbing	Other:_____				

Pain Level 0 = No Pain 10 = worst imaginable

When it first started?	0 1 2 3 4 5 6 7 8 9 10
Currently at its WORST?	0 1 2 3 4 5 6 7 8 9 10
Currently at its BEST?	0 1 2 3 4 5 6 7 8 9 10

What makes the pain worst?

Lying flat	Cooking	Twisting	Getting up out of bed	Carrying items
Lifting anything	Dressing/grooming	Stairs	Lifting heavy weights	Pulling
Raising arms	Looking up/down	WalkingOther:_____		

What relieves the pain?

Ice	Heat	Pain Medication	Lying flat	Stretching
Avoiding Activity	Exercising	Nothing	Other: _____	

Vitals

Height:_____ Weight:_____ BP:_____ Pulse O2: _____

Falls

How many times have you fallen in the past year?_____

Were you injured? _____

Tobacco use

Do you currently: __ smoke tobacco __ snuff tobacco __ chew tobacco __ vape

Have you ever smoked? _____ How long? _____ When did you quit? _____

Have you ever received advice or counseling to help you stop using tobacco? _____

Consent to Treat

I, _____, (patient name) give permission for Back in Action Physical Therapy or their representative(s) to treat me for the aforementioned condition(s).

I allow Back in Action Physical Therapy to file insurance benefits to pay for the care I receive. I understand that Back in Action Physical Therapy will have to send my medical record information to my insurance company, that I must pay my share of the costs, and that I must pay for the cost of these services if my insurance company does not pay or I do not have insurance.

I understand that I have the right to refuse any procedure or treatment that I have the right to discuss all treatments with my clinician.

_____ _____

Signature Date