Who may we thank for referring you to our practice?

___________________________

**Today's date:**____________

# Confidential Patient Information

***Please complete this questionnaire. This confidential history will be part of your permanent records. Thank you!***

**Patient's Full Name** _______________________________________**Age**________ **Date of Birth**_______________

**Address:**____________________________________ **City** _________________ **State**_____ **Zip**________________

**Primary Phone:**______________________**(Home/Work/Cell) Sex: ❑M ❑F SSN:**
_________________________

**Email Address:** ________________________________ **( for treatment and appointment communications)**

**Occupation:** _________________________ **Employer:** ____________________________________

**Emergency Contact Name/ Relation:** ________________________________________ **Phone#:** ______________

**INSURANCE POLICY HOLDER :** ____________________________________**RELATIONSHIP:** ______________

**DOB OF INSURANCE POLICY HOLDER:** _________________________

## CURRENT MEDICAL HISTORY

**What is your major complaint/ problem/restriction(s)?**__________________________________________________

_____________________________________________________________________________________________

**Date of Onset?** ________________ **What caused this condition?** ________________________________________
**Is this condition: ❑ Job related ❑ Auto Accident ❑ Other:**___________________________

**What WORSENS this condition (CIRCLE): What makes it BETTER (UNDERLINE):**

**sitting (tolerance in minutes_____) // driving (max time in minutes:_______)// moving sit to stand //**

**standing prolonged (tolerance in min._____) // walking (max distance_____) // lying down// kneeling //**

**squatting // dressing // bending // lifting (max weight in lbs:_____) // reaching // twisting //**

**arising in AM // end of day // your work/job // exercise // stretching // rest or sleep // ice // heat //**

**other:**____________________________________________________________________________

**Is this condition interfering with: ❑Work/School ❑Sleep ❑Daily Routine ❑ Other:**___________________
_

**Is this condition: ❑Improving ❑Unchanged ❑Getting Worse**

**Do you have a REFERRING physician (order) for this condition? ❑No ❑Yes--> Name:**______________________

**Is this your PRIMARY DOCTOR ? ❑Yes ❑No---> Name of primary:**___________________________________
**Can we send reports to your primary doctor ❑Yes ❑No**

**PAST TREATMENT for THIS Condition :**_____________________________________________________
__________________________**When?**_______________________ **Number of PT or OT visits this year** ____________
**Prior to this injury/problem did you have limitations with your daily activities? Y / N (circle) If yes, please explain.**_________________________________________________________________________________

_____________________________________________________________________________________________

**Have you had this or similar conditions in the past? ❑Yes ❑No If Yes, when?_______________________**

**Have you previously been in an auto accident or had any other personal injury? ❑Yes ❑No**
**If yes, please describe: ________________________________________________________________**

**Medications, dosage and frequency: (If many please use separate form);____________________________________**

______________________________________________________________________________________

**PERSONAL HEALTH HISTORY:**

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:**

❑ **AutoImmune:________________**
❑ **High blood pressure med** Controlled? Y/N
❑ **Infectious Disease** type:_________________
❑ **Epilepsy/Seizures** Last:________________
❑ **Dizziness/ fainting**
❑ **Cancer** Form:____________ Treatment:_____________________
❑ **Bowel/ bladder problems** Urge/ Stress/ prolapse/constipation/diarrhea
❑ **Depression/Mental Illness** treatment?:
❑ **Severe Headaches** Days/Week_____________
❑ **Heart attack/Stroke** Date:_____________
❑ **Osteoporosis** Controlled? Y/N
❑ **Diabetes** Type I / II ?
❑ **Chest Pain**
❑ **Asthma** Last Episode:________
❑ **Smoking** Ppd_____ Years___________
❑ **Drug/ Alcohol Abuse**
❑ **Pacemaker**
❑ **Severe Allergies** To:_______________
❑ **Blood clots** When/Where?______________
❑ **HEAD INJURY/Concussion** when?____________
❑ **TMJ, Jaw pain**
❑ **Extensive DENTAL work** describe: __________________

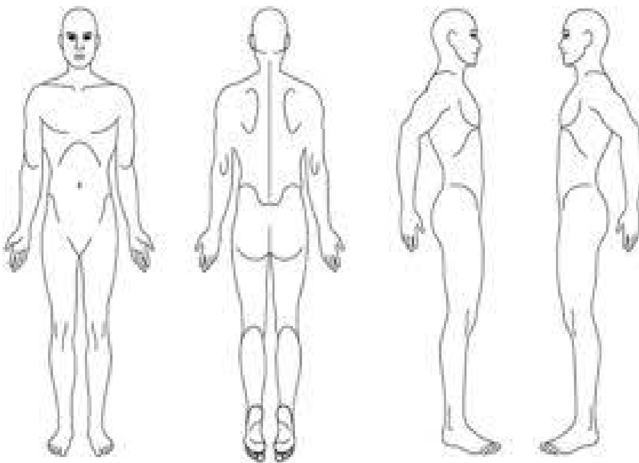
Please clarify any above checks in the section below:

________________________________________
________________________________________
________________________________________
________________________________________
_____________________________

SURGERIES/dates:____________________
________________________________________
________________________________________

X RAYS/MRI: Y/N RESULTS?
____________________________________

CURRENT WEIGHT:____________
CURRENT HEIGHT:_____________
CURRENT SHOE SIZE:___________



**PAIN INTENSITY:**

**Please mark your symptoms on the figures accordingly:**

**!** = stabbing *****= aching **//**= burning **#** = numbness/tingling

*Rate the intensity of your pain from 0 to 10 with "0" denoting no pain and "10" denoting most severe pain.*

**How bad are your symptoms now? ____/10**

**How bad have they been in the past week? ____/10**

**What is the least pain in the past week? ____/10**

**Most painful activity?___________________________________**

**Night pain? Y/N Sleep Disturbed? Y/N Hours of Sleep________**

One activity you would love to do that you cannot do now: ____________________________________________

What are your goals for physical therapy? ______________________________________________________

**Females only**: Are you pregnant, planning a pregnancy or nursing a child? Y/N Do you have an IUD implanted ? Y/N

**Signature confirming above information is correct and updated:______________________________ DATE:________**

(parent /Guardian of minor ❑**Yes** ❑**No** ) 3/2021