

New Patient Information

Please print clearly

Date: ____/____/____

Patient Name: _____ Sex: Male Female
Last First M.I.

Address: _____
Street City State Zip

Parent or Guardian (if patient is a minor): _____

Is patient employed? Yes No Full-time student Occupation: _____

Employer or School: _____ Marital Status: Married Single Other

Home Phone: (____) ____-____ Work Phone: (____) ____-____ ext. ____

E-mail: _____

Date of Birth: ____/____/____ SS#: ____-____-____

Referring Dr.: _____
Name Address Phone

Primary Care Dr.: _____

How did you hear about our office? _____

EMERGENCY CONTACT (not living with patient): _____

Phone: (____) ____-____ Relationship: _____

Insurance Information:

Primary Insurance Co: _____

Group #: _____ Policy I.D./Claim #.: _____

Is patient the subscriber? Yes No **If no, then:**

Subscriber's Name: _____ Subscriber's Employer: _____

Relationship to Patient: _____ Subscriber Date of Birth: ____/____/____

In Order to Bill Your Insurance, We Must Have a Copy of Your Insurance Card.

Injury Information:

Condition is related to: Work Auto Home Sports Other None

Date of injury/onset of condition: ____/____/____

Body side: Right Left Both Body part affected: _____

Vocational Rehab Counselor or Claims Manager or Attorney:

Name: _____ Phone (____) ____-____

E-mail: _____ Fax (____) ____-____

Address: _____
Street City State Zip

For Office Use Only Therapist: _____ Core Number: _____
 Dx Codes: _____

Core Physical Therapy, P.C.

Core Physical Therapy, P.C.
(Confidential)



Core Physical Therapy
Belltown Physical Therapy

Patient Name: _____ Date: _____

Referring Physician: _____

Please describe below the problem you are here for today, how and when it occurred, and the location of the pain / discomfort:

What type of pain are you experiencing?

Throbbing Sharp Aching Tingling Burning Numbness Shooting

Which Activities increase your symptoms?

Sitting Twisting Lifting Rising Walking Standing
 Bending Driving Reaching Squatting Kneeling Reclining
 Stairs Other: _____

What eases your symptoms?

Moist heat Medication Change in position Ice Rest Other: _____

Is your condition overall:

Improving Getting worse Staying the same

Have you had any treatment for this condition in the past? Yes No

Please list all: _____

Have you received any of the following tests for this problem?

X-rays Nerve conduction study CT scan MRI
 Bone scan EMG Other: _____

How would you rate your overall health?

Poor Fair Good Excellent

What is your present: Height: _____ Weight: _____ lbs.

Are you able to continue working? Yes No

If no, when did you last work?

Are the physical demands of your job? Light Moderate Heavy

Are you able to continue your recreational and sporting activities? Yes No

Specifics:

What are your goals and expectations for physical therapy? _____

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Core Physical Therapy
Belltown Physical Therapy

Patient's Name: _____

Today's Date: _____

Please answer all questions in reference to your current status.

Are you currently working? Yes No
 Full-Time Part-Time
 Light Duty Regular Duty Heavy Duty

Are you able to continue your recreational and sports activities? Yes No

	I Cannot!	Less than 5 minutes	Less than 15 minutes	Less than 45 minutes	Between 1-2 hours	Normal
How long can you sit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long can you stand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long can you walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long can you drive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	I Cannot!	Less Than 5 lbs.	Less Than 15 lbs.	Less than 25 lbs.	Between 25-60 lbs.	Normal
How much can you lift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you carry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	1x	2-10x	11-25x	Normal
Can you squat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you kneel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you bend/stoop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Can you climb stairs/hills?	Yes	No			
Does pain disrupt your sleep?	Yes	No			
Can you reach overhead?	Yes	No			
Do you have headaches?	Yes	No	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
Do you take medication for pain relief?	Yes	No	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	
Do you have difficulty reading?	Yes	No			
Are you performing exercises?	Yes	No			

What treatment other than physical therapy do you receive? _____

List all of the medications you are currently using: _____

Current Level Of Pain (circle) 0 1 2 3 4 5 6 7 8 9 10
Maximum Functional Capacity (circle) 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Please Describe all other limitations:

Confidential Health History

Patient Name _____ Date _____
 Age _____ Birthdate _____ Date of Last Physical Examination _____
 What is the reason for your visit? _____

Symptoms

Check (✓) conditions you currently have or have had in the past year.

General

- Chills
 Depression
 Dizziness
 Fainting
 Fever
 Forgetfulness
 Headache
 Loss of sleep
 Loss of weight
 Nervousness
 Numbness
 Sweats

Muscle/Joint/ Bone

Pain, weakness, numbness in

- Arms Hips
 Back Legs
 Feet Neck
 Hands Shoulders

Genito-Urinary

- Blood in Urine
 Frequent urination
 Lack of bladder control
 Painful urination

Gastrointestinal

- Appetite poor
 Bloating
 Bowel changes
 Constipation
 Diarrhea
 Excessive hunger
 Excessive thirst
 Gas
 Hemorrhoids
 Indigestion
 Nausea
 Rectal bleeding
 Stomach pain
 Vomiting
 Vomiting blood

Cardiovascular

- Chest pain
 High blood pressure
 Irregular heart beat
 Low blood pressure
 Poor circulation
 Rapid heart beat
 Swelling ankles
 Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums
 Blurred vision
 Crossed eyes
 Difficulty swallowing
 Double vision
 Earache
 Ear discharge
 Hay fever
 Hoarseness
 Loss of hearing
 Nosebleeds
 Persistent cough
 Ringing in ears
 Sinus problems
 Vision – Flashes
 Vision – Halos

Skin

- Bruise easily
 Hives
 Itching
 Change in moles
 Rash
 Scars
 Sore that won't heal

MEN only

- Breast lump
 Erection difficulties
 Lump in testicles
 Penis discharge
 Sore on penis
 Other

WOMEN only

- Abnormal Pap smear
 Bleeding between periods
 Breast lump
 Extreme menstrual pain
 Hot flashes
 Nipple discharge
 Painful intercourse
 Vaginal discharge
 Other

Date of last menstrual period: _____

Date of last _____

Pap Smear _____

Have you had _____

A mammogram? _____

Are you pregnant? _____

Number of children _____

Symptoms

Check (✓) conditions you currently have or have had in the past year.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Live Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

Medications List medications that you are currently taking

Pharmacy Name: _____ Phone: _____

Allergies

Family History

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following	
					✓ Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

***Hospitalizations**

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates: _____

Serious Illness/Injuries	Date	Outcome

Pregnancies***Health Habits******Occupational***

Year of Birth	Sex of Birth	Complications, if any	Check (✓) which substances you use and describe how much you use		Check (✓) if your work exposes you to the following:	
			Caffeine		Stress	
			Tobacco		Heavy Lifting	
			Drugs		Hazardous Substances	
			Other		Other	
						Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor/therapist or any members of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date

Reviewed By

Date