Patient History

Patient's Name: ______________________________________ Date of birth: ________________

Address: ____ City: _______________________

State: _____________________ Zip code: ____________ County: ________________________

Email: _____________________________ Work: _______________ Cell: __________________

Emergency Contact: _______________________________________ Phone: ________________

Appointment reminder preference: email ____________ phone ___________ text__________

Occupation: ____

Primary Insurance (Name of Company): ____

Name of Insured (subscriber): ____

Subscriber's Date of Birth: ________ Subscriber's Employer: ______________________________

Policy #: __________________________________ Group #: ______________________________

Insurance provider customer service phone #: ____

Secondary Insurance (Name of Company): ____

Name of Insured: ____

Policy # _____________________________ Group # ______________________________________

Subscriber's Date of Birth: _________ (additional information will be obtained from the copy of the insurance card)

Primary care physician _____________________ Location (City and Zip) ___________________

Referring Physician: _____________________ Location (City and Zip) ______________________

Date and location of follow up with referring physician: _________________________________

Specialists (Other Physicians) seen for this injury or condition: ___________________________

Reason for referral: ____

Diagnosis: _________________________ Date of onset of injury: _______________________

Mechanism of injury: ____________________Location of injury: ________________________

List all Medications currently taking, including over the counter: And Dosages

____

____

Previous Medical History: ____

Diagnostic tests and dates (X-ray, MRI, etc.):

____

Previous and current providers seen (massage therapist, acupuncture, chiropractor, etc.): ____

____

Pain Rating 0-10 scale (with ten being the worst): ________ Is pain constant Y/N? __________

Describe pain (burning, dull ache, or sharp): ____

Position(s)/activity(s) makes the pain: Worse? ________________ Better? _________________

What daily activities do you have difficult with or are unable to participate in since the injury or condition? ____

Level of activity prior to injury or condition: ____

Goals of physical therapy (activities you want to return to or begin after completion): ________

____

Patient Signature: _________________________________ Date: _______________________