



New Patient Verification:

First Name: _____ *Middle Initial:* ____ *Last Name:* _____

Sex: _____ *Age:* _____ *Date of Birth:* _____

Address: _____

City: _____ *State:* _____ *Zip Code:* _____

Home / Mobile#: () _____ - _____

Email: _____

Marital Status:

Single _____ *Married* _____ *Divorced* _____ *Widowed* _____ *Domestic Partner* _____

Employer's Name: _____ *Occupation:* _____

Emergency contact: _____ *Phone #* () _____ - _____

How did you hear about us? (Check one box)

Family / Friend: _____

Facebook

Instagram

Other: _____

Patient's signature: _____

Date signed: _____

PHYSICAL THERAPY PATIENT HISTORY

Are you off work because of this problem? Yes No Light duty

When and how did your problem start? _____

Have you previously consulted a physician or healthcare provider regarding this condition?

Yes → **Please Provider name and phone number:** _____

No

Pain Level (circle one): No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Draw where you feel pain: (use diagram)

Type of pain:

Aching Sharp Stabbing Burning

Shooting Pins & needles

Numbness/Tingling

Other: _____

Is your pain: Constant? Yes No

Worse with activity? Yes No

Waking you at night? Yes No

What makes pain worse?

Sitting Standing Walking Lifting

Bending Lying down Stress

Other: _____

Are you ever pain free? Yes No

What makes pain better? Sitting Standing Walking Lying down Other: _____

Symptoms are worse: _____ best: _____ (AM or PM)

Overall, are you: Getting better Getting worse Staying the same

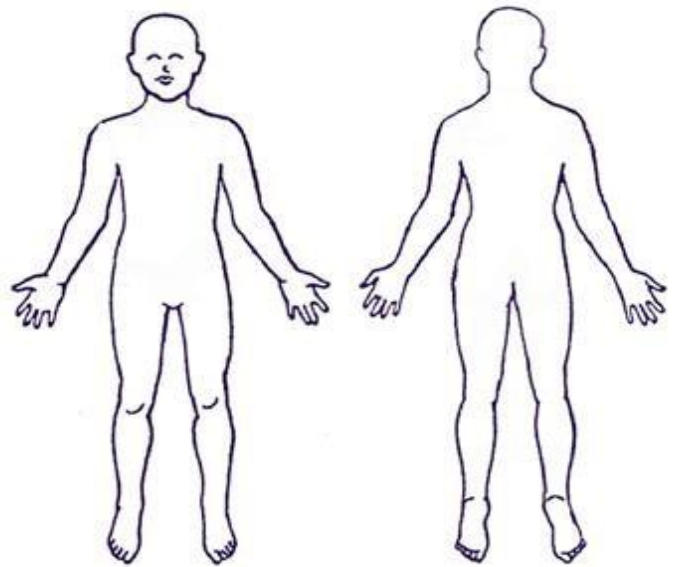
Have you had imaging tests? (X-ray, MRI, CT, etc.) Yes No

History of blood clots? Yes No Pacemaker or implanted device? Yes No

Previous surgeries? Yes No If yes: _____

Medical problems? Yes No If yes: _____

Goals for physical therapy: _____



Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

HIPAA Privacy Acknowledgment & Communication Consent

I acknowledge that I have received or have been given access to the practice's Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed in accordance with HIPAA.

A copy of the Notice of Privacy Practices is available at the front desk.

I understand that my PHI may be used for treatment, payment, and healthcare operations as permitted by law.

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken.

Communication Preferences:

May we contact you to confirm appointments or provide information related to your care?

Phone Text Email No contact

May we leave a voicemail or message on your phone?

Yes No

May we discuss your medical information with family members or other individuals?

Yes No

If yes, please list names: _____

Patient Name: _____

Signature: _____

Date: _____