**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: / / SSN: \_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_

**Referring Provider:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of last MD visit**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next MD appointment scheduled**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**height**:\_\_\_\_\_\_\_\_\_\_ **weight**:\_\_\_\_\_\_\_\_\_\_\_

**Reason for therapy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date symptoms began**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other therapy/treatment for this condition**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY NAME AND PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check yes or no for each question as it pertains to your medical history:***

Yes No Yes No

Previous similar injury □ □ Physical Therapy □ □

High Blood Pressure □ □ Kidney Problems □ □

Cardiac Conditions/heart attack □ □ Liver Problems □ □

Fibromyalgia □ □ Cancer □ □

Lung problems □ □ Lymes Disease □ □

Circulation /Blood clots □ □ Claustrophobia □ □

Pacemaker □ □ Mental Health Condition□ □

Seizures □ □ Vision Problems □ □

Dizzy Spells/fainting/vertigo □ □ Depression □ □

Diabetes □ □ Metal Implants □ □

Allergies/ Asthma □ □ Aids/HIV Positive □ □

Fractures □ □ Stroke □ □

Arthritis □ □ Could you be pregnant? □ □

Other conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you recently noted:***

Nausea/ vomiting? □ Fatigue?□ Weakness?□ Fever/chills/sweats? □ Numbness or tingling?□

Please list all surgeries, fractures, illnesses, symptoms or injuries pertinent to this current issue and the dates of occurance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke?\_\_\_\_\_\_ Do you use street drugs?\_\_\_\_\_\_\_\_\_\_\_\_ which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?\_\_\_\_\_\_\_\_\_\_\_\_\_ How many drinks/ week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please place a check next to any of the tests you have had for this condition: (give dates of test)

X-ray\_\_\_\_\_\_\_\_\_\_ CT scan\_\_\_\_\_\_\_\_\_\_\_ MRI\_\_\_\_\_\_\_\_\_\_\_ EMG\_\_\_\_\_\_\_\_\_\_\_ NCV\_\_\_\_\_\_\_\_\_

Myelogram \_\_\_\_\_\_Bone Scan \_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please describe)

***Please list all medications that you are currently taking***

(or provide a separate list and check here □)

***Medication name: Dosage Frequency Route***

(include prescriptions, OTC, herbal and nutritional supplements) (amount) (how often)

**oral sub-lin inject vapor topical** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ □ □ □ □ □

I agree to alert my therapist if there is any change to the above list at any time during my therapy. (please initial here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Are you allergic to any medications? Yes No If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving any home care services? Yes No **(If “YES” please contact the front desk immediately to discuss as this will affect your insurance coverage here)**

Have you had any falls in the last 12 months? Yes No

If so, how many?\_\_\_\_\_\_\_\_ Please describe the incident (s) and any injuries associated with the falls:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above information is true and complete to the best of my knowledge:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient Signature) Date