"Reaching Peak Performance"

Valdosta Physical Therapy, Inc.

Patient's Information

(Circle one): New Patient / Return Patient Patient #(Front desk will provide):_____

Name: First:_____Middle:_____Last:_____

Street Address:_____

City:_____State:_____Zipcode:_____

Cell Phone:_____Home/Alternate Phone #:_____

Date of Birth:_____Age:_____Social Security #:_____

Marital Status (circle one): Married / Single / Widowed / Separated / Divorced

E-mail:_____Emergency Contact Name and #:_____

Employment Information

(Circle one): Employed / Unemployed / Retired / Student

Employer/ School:_____Occupation:_____Phone #:_____

Employment Address:_____City/State/Zipcode:_____

Spouse and Parent Information

Spouse/ Parent Name:_____Phone #:_____

Address:_____City/State/Zip Code:_____

Date of Birth:_____Employer:_____

Insurance Information

Primary insurance:_____

Secondary insurance:_____

*******Please provide the front desk with your insurance card so we may make a copy for your file.*

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Physician Information

Referring Physician:_____Primary Physician:_____

How did you hear about us?

Please check one:

☐Returning patient ☐Phonebook

☐Physician ☐Word of Mouth

☐Internet *Name of referrer*_____

☐Employer ☐Other

*List other*_____

Patient Medical History

Height:____ft.____in.

Weight:_____lbs.

Where are your symptoms located? (Darken the spots on the appropriate body above)

When did your symptoms begin?_____

Circle the words that best describe your symptoms: sharp / dull / burning / cramping / localized / radiating

Are your symptoms due to an accident or trauma?(describe)_____

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What makes you feel better?_____

What makes you feel worse?_____

Please rate the following on a scale of 0-10 (0 being no pain, 10 being the worst pain you can imagine):

1. The least pain you've had in the past week: _____ out of 10
2. The most pain you've had in the past week: _____ out of 10
3. Your current level of pain: _____ out of 10

Please list any relevant medical history:_____

Please provide all current medications you are taking, including dosage (if multiple, please provide a list for the chart):_____

Please list any diagnostic test results (X-rays, MRI, CT scan, Myelogram, etc.):_____

_____

Please list any interventions prior to physical therapy (injections, splints, medications, etc.):_____

If 100% represents full recovery and full functioning for you, what percent are you at today?_____

Do you have any previous medical problems that may limit your ability to exercise?
(Circle one): Yes / No

If yes please explain:

_____

Please mark if you had or have any of the following problems (choose all that apply):

☐Pace maker	☐Infections	☐Bowel/Bladder
☐Heart attack	☐Diabetes	☐Metal Implants
☐Headaches	☐Cancer	☐Dizziness
☐Stroke	☐Hernia	☐HIV
☐Heart Disease	☐High Blood Pressure	☐Insomnia
☐Hepatitis		Females only: Pregnant: ☐ Yes ☐ No