HUNGERFORD
CHIROPRACTIC & PHYSICAL THERAPY

NEW PATIENT INFORMATION SHEET

PATIENT

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

Gender: M F Date of Birth: ___/___/___ Age: ___ SS#: _____ How many children?____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Ph: (___)_____ Cell Ph: (___)_____ Work Ph: (___)_____

Employer Name: _____ Occupation: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____@_____

☐ Please check here if you agree with email notifications to the specified email address listed above for appt. reminders. Please also note, we will not send you junk mail or pass on your email address to anyone else.

SPOUSE or GUARDIAN

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

Employer Name: _____ Work Phone: _____

EMERGENCY *(Name and address of the nearest relative or friend not living with you)*

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

Home Phone # (_____)_____ Work Phone # (_____)_____

Relationship to Patient: _____

INSURANCE

Primary Insurance Company: _____

Insured's Name: _____ Insured Date of Birth: ____/____/____

Secondary Insurance Company: _____

Insured's Name: _____ Insured Date of Birth: ____/____/____

RESPONSIBLE PARTY *(Complete this section if someone other than the patient is responsible for the bill.)*

Responsible Party: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone # (_____)_____ Work Phone # (_____)_____

Employer Name: _____ Occupation: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Is this condition due to an injury arising out of employment? Yes No

Is this condition due to an injury arising out of an auto accident? Yes No

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

HUNGERFORD
CHIROPRACTIC & PHYSICAL THERAPY

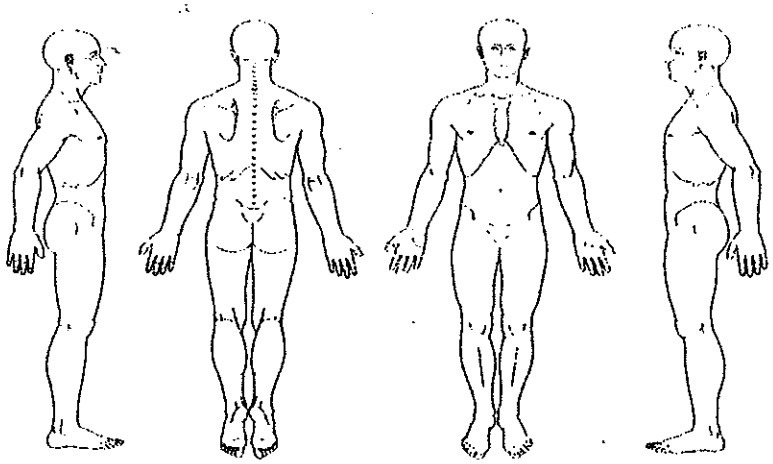
Physical Therapy Health Questionnaire

Patient Name: _____ **Date:** _____

1. **Describe your primary problem (reason for physical therapy):** _____

_____

2. **Please CIRCLE on the diagram where your symptoms are located:**



3. **How bad are your symptoms? (0 is NO Pain - 10 is Unbearable Pain)**

AT THEIR BEST:	0	1	2	3	4	5	6	7	8	9	10
AT THEIR WORST:	0	1	2	3	4	5	6	7	8	9	10

4. **Please indicate if you have any of the following (X if YES - leave blank if NO)**

____Diabetes	____Varicose Veins	____Neurological Problems
____Rheumatic Fever	____Circulatory Problems	____Stroke
____Heart Murmur	____Lung Disease	____High Blood Pressure
____Epilepsy	____Kidney Disease	____Heart Disease
____Cancer	____Broken Bones	____Migraine Headaches
____Arthritis	____Liver Disease	____Dizziness
____Osteoporosis	____Metal Implants	____Other (LIST)

---- OVER ----

5. **List any hospitalization with reasons and dates:** _____

_____

6. **List any surgeries and include dates:** _____

_____

7. **List any medications you are currently taking:**

___Anti-Coagulants ___Pain Meds ___Muscle Relaxants ___Anti-Inflammatories ___Steroids ___Other

8. **Please answer YES or NO to the following questions:**

Do you have a pacemaker? Y / N	Do you engage in regular exercise? Y / N If YES, what type & how often? _____
Do you have skin allergies? Y / N	Do you have discomfort, shortness of breath, or pain with exercise? Y / N
What is your occupation? _____	Is there any reason that you should not exercise? Y / N If YES, list reason(s) _____
Do you consume drugs and/or alcohol? Y / N If YES, what type? _____	WOMEN: Any chance you are pregnant? Y / N

9. **Please list 3 activities limited by your injury. (Example: Unable to sit for more than 30 minutes)**

1. _____
2. _____
3. _____

10. **What are the goals you expect to reach with physical therapy?** _____

_____

11. **Have you received physical therapy treatments any time in the last 12 months?** Y / N

12. **Have you received or are you currently receiving any other treatment for this condition?**

_____ PT _____OT _____Chiropractor _____Other _____

13. **In case of an emergency, who should be notified? (List Name and Phone #)** _____

_____

_____ _____

PATIENT SIGNATURE **DATE** **THERAPIST SIGNATURE** **DATE**