Last Name:	**First Name:**	**Middle Initial:**
Date of Birth: / /	**S.S.N:**	
Sex at Birth:	**Gender Identity:**	**Gender Pronoun:**
Address:		
Home Phone:	**Cell Phone:**	
Email Address:		**❑ No Email**
Preferred Appointment Reminder: ❑ Text ❑ Email ❑ Both		
Employer:	**Status: ❑ FT ❑ PT ❑ None ❑ Retired ❑ Student**	
Work Phone:	**Occupation:**	
Emergency Contact:	**Relationship:**	
Phone Number:	**Email:**	
Emergency Contact:	**Relationship:**	
Phone Number:	**Email:**	
Referring Physician:		**Script: ❑ Yes ❑ No**
Injury Date:	**Surgical Date:**	
Work Related: ❑ Yes ❑ No	**Accident Related: ❑ Yes ❑ No**	**Auto Related: ❑ Yes ❑ No**
Date of Injury:	**Claim #:**	**Accident Insurance:**
Adjuster:	**Phone Number:**	
Attorney:	**Phone Number:**	
Primary Insurance Plan:	**ID#**	**Group#**
Address:		
Secondary Insurance Plan:	**ID#**	**Group#**
Address:		

Patient or Representative, please sign below if the above information is correct:

Signature: **Date:**

***** THIS FORM MUST BE SCANNED INTO THE PATIENT'S EMR *****

Name:	DOB:	Nickname:
What is your primary injury/Condition?		
Date of Injury or Onset of Pain:	**Date of Surgery:**	
If this is an injury, how did it occur?		
Please rate your pain on a scale of 0 to 10 (0 is no pain, 10 is for worst pain):		

Have you had an imaging done (x-rays, MRI)?	❑ YES ❑ NO	If so, what type & when?

Have you received any rehabilitative services for this condition or any other since January of this year?		
❑ YES ❑ NO	If **YES**, what type:	How many visits?
Are you scheduled for any upcoming surgical procedures?		❑ YES ❑ NO

Are you allergic to latex	❑ YES ❑ NO	Do you have any implants?	❑ YES ❑ NO
Do you smoke or vape?	❑ YES ❑ NO	Do you use drugs or alcohol?	❑ YES ❑ NO
Do you wear glasses?	❑ YES ❑ NO	Do you wear a hearing aid?	❑ YES ❑ NO
Do you have a pacemaker?	❑ YES ❑ NO	Are you pregnant?	❑ YES ❑ NO
Are you taking any blood thinners/anticoagulant medications?			❑ YES ❑ NO
Are you allergic to any foods or medications?	❑ YES ❑ NO	If **YES**, explain:	

Please check any & all condition(s) you currently have or have had in the past:

❑	Emotional & Psychological Problems	❑	Diabetes	❑	High Blood Pressure
❑	Coronary Heart Disease, Angina	❑	Blood Clot, DVT, Emboli	❑	Dizziness, Lightheaded
❑	Heart Attack, Heart Surgery	❑	Asthma, Bronchitis	❑	Vision Difficulties
❑	Severe or Frequent Headaches	❑	Emphysema, COPD	❑	Hearing Difficulties
❑	Shortness of breath	❑	Weight Loss, Weight Gain	❑	Sleeping Difficulties
❑	Stroke, CVA, TIA	❑	Varicose Veins	❑	Epilepsy, Seizures
❑	Thyroid, Goiter	❑	Traumatic Brain Injury (TBI)	❑	Numbness, Tingling
❑	Kidney Disease	❑	Balance Problems	❑	Ears, Nose & Throat
❑	Memory Deficits	❑	Hernia	❑	Depression, Anxiety
❑	MVA Accident	❑	Lyme Disease	❑	AIDS, HIV
❑	Neurological Conditions (Parkinsons, Alzheimers, MS, ect..)			❑	Rheumatoid Arthritis (RA)
❑	Other:				

If any of the following apply, please check and provide specific information:

❑	Muscle Weakness	❑	Bowel or Bladder Dysfunction	❑	Cancer
❑	Osteopenia/Osteoporosis	❑	Arthritis, swollen joints	❑	Leg/Ankle/Foot Injury/Surgery
❑	Shoulder Injury/Surgery	❑	Joint Replacement	❑	Back Injury/Surgery
❑	Neck Injury/Surgery	❑	Elbow/Hand Injury/Surgery	❑	Knee Injury/Surgery
Specific Information:					

Patient Signature: _____ Date: _____

***** THIS FORM MUST BE SCANNED INTO THE PATIENT'S EMR *****

MEDICATIONS

Prescriptions	Dosage

Over the Counter Medications	Dosage

Vitamins or Herbal Supplements	Dosage

Patient or Representative, please sign below if the above information is correct:

Signature: **Date:**

***** THIS FORM MUST BE SCANNED INTO THE PATIENT'S EMR *****