River Light Community Physical Therapy, LLC

New Patient Information Sheet

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

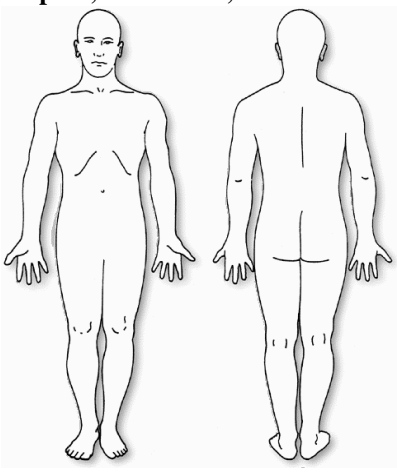
Name:	Last Name	First Name		Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



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Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?				Yes	No
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).
If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**
I stand for		**minutes before needing to sit**
I sit for		**minutes before needing to change positions/get up**

Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

Patient Goals
Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Informed Consent

I understand that River Light Physical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools only. By signing below I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for River Light Community Physical Therapy to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:_____

Date:_____