NEW PATIENT INFORMATION FORM

(Please print your name as it is shown on your insurance card.)

PATIENT INFORMATION

Patient's First Name:_____ MI: _____ Last Name: _____ Date of Birth: _____/_____/_____

Social Security #: (not required but helpful for ins)

[ ]Male
[ ]Female

Mailing Address: _____ Street Address (if different): _____

City: _____ State: _____ Zip Code: _____ Primary Contact no: _____

Email Address: _____

Occupation: _____

Emergency Contact Name: _____

Emergency Contact Phone No.: _____

Referred to clinic by (please check one box):

○ Medical Provider ○ Drive By ○ Google/Internet Search ○ Google Review ○ Printed Advertisement ○ Previous Patient
○ Referred by a PT ○ Insurance Company Referral ○ Social Media ○ Direct Mail ○ Radio ○ Friend/Family
○ Referral from Another Patient ○ Attended Workshop/Injury Screening ○ Clinic Website ○ Other_____

Referring Physician Name and Phone Number:

_____

Primary Care Physician Name and Phone Number:

_____

INSURANCE INFORMATION
(ALSO COMPLETE NEXT PAGE IF WORKERS COMP OR NO FAULT/AUTO)

Primary Insurance Plan: (i.e. BCBS)

Insured's ID Number: _____

Insured's Policy Group #: _____

Insured's Name: _____

Insured's Address: _____
(if different)

Insured's City: _____

Insured's State: _____

Insured's Zip Code: _____

Insured's Phone #: _____

Insured's Birth Date: _____

Insured's Gender: _____

Insured's Employer: _____

Relation to Insured: _____

Secondary Insurance Plan: (i.e. BCBS)

Insured's ID Number: _____

Insured's Policy Group #: _____

Insured's Name: _____

Insured's Address: _____
(if different)

Insured's City: _____

Insured's State: _____

Insured's Zip Code: _____

Insured's Phone #: _____

Insured's Birth Date: _____

Insured's Gender: _____

Insured's Employer: _____

Relation to Insured: _____

ACCIDENT DETAILS: PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: ◯ YES ◯ NO

Accident related: ◯ Auto ◯ YES ◯ NO

Date of first symptom or accident: _____/_____/_____

If auto accident related, please indicate in which state the accident occurred: _____

_____

Give details of accident and complete next page if accident related:

_____

_____

_____

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits directly to this practice for the services rendered.

Patient/Guardian Signature: _____ Date _____/_____/_____

ONLY COMPLETE IF THIS IS A WORKER'S COMPENSATION OR NO FAULT/AUTO CASE

Workers Comp Carrier Name:

Insurance Co. Address: _____

Insurance Co. City: _____

Insurance Co. State: _____

Insurance Co. Zip: _____

Carrier Case/Claim #: _____

WCB #: _____

Case Mgr./Adjuster Name: _____

Case Mgr./Adjuster Phone #: _____

Employer's Name: _____

No Fault/Auto Case Insurance Name:

Insurance Co. Address: _____

Insurance Co. City: _____

Insurance Co. State: _____

Insurance Co. Zip: _____

Carrier Case/Claim #: _____

WCB #: _____

Case Mgr./Adjuster Name: _____

Case Mgr./AdjusterPhone #: _____

Employer's Name: _____

PATIENT HISTORY FORM

☐ Name: _____ Age: _____ DOB: _____ Occupation: _____

Leisure activities, including exercise routines: _____

Primary Care Physician/Family Physician: _____

Are you on a work restriction from your doctor? ☐YES ☐NO Do you smoke? ☐YES ☐NO

Are you latex sensitive? ☐YES ☐NO Please list any known allergies _____

Do you have a pacemaker or defibrillator? ☐YES ☐NO Do you have cancer? ☐YES ☐NO If "yes", how active is your cancer _____

Do you have a stimulator of any kind (brain stimulator, pelvic stimulator, etc.)? ☐YES ☐NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐YES ☐NO

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ falls
- ☐ difficulty maintaining balance
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ diarrhea
- ☐ constipation
- ☐ changes in bowel/bladder function
- ☐ difficulty swallowing
- ☐ shortness of breath
- ☐ fainting
- ☐ cough
- ☐ headaches
- ☐ currently feeling down or hopeless

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency
- ☐ Depression
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Sexually transmitted disease/HIV
- ☐ Incontinence
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Kidney problems
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Other: _____

Please list prior surgeries and date(s) _____

Date of injury/onset of current symptoms: _____ Date of surgery: _____

What do you think caused your symptoms? _____

Please MARK any of the following services that you have received in the last 12-months:

☐ Physical Therapy ☐ Occupational Therapy ☐ Chiropractic Care ☐ Massage Therapy ☐ Speech Therapy ☐ Home Health

Have you had any of the following for your current problem ☐ X-Ray ☐ Injection ☐ MRI ☐ CT Scan ☐ Other: _____

Have you ever had this problem before? ☐ **YES** ☐ **NO** If yes, when? _____

In your current living environment: Do you have stairs? ☐ **YES** ☐ **NO** Do you live alone? ☐ **YES** ☐ **NO**

How would you rate your overall quality of life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

1. _____
2. _____
3. _____

Name: _____ DOB:_____

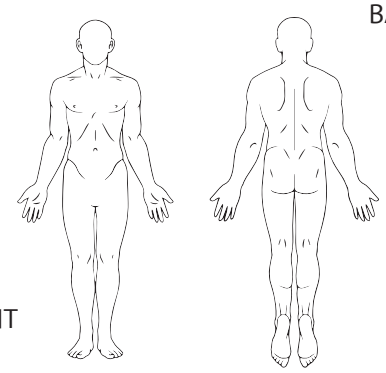
Using the scale below, maark the WORST your pain has been during the past 24 hours. 0 = no pain, 10 = worst pain imaginable

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

On the chart to the right, please mark the areas where you feel PAIN with an "O" and NUMBNESS/TINGLING with an "X".

BACK



FRONT

MEDICATION ASSESSMENT:

Please list any medications you are currently taking (including pills, injections, skin patches, vitamins, herbs, etc):

Medication Name	Dosage	Frequency	Route of Administration (mark how you take this med)
			☐ mouth ☐ injection ☐ patch
			☐ mouth ☐ injection ☐ patch
			☐ mouth ☐ injection ☐ patch
			☐ mouth ☐ injection ☐ patch
			☐ mouth ☐ injection ☐ patch
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			☐ mouth ☐ injection ☐ patch
			☐ mouth ☐ injection ☐ patch

"Once you have completed this form, please save a copy and email it to the designated recipient for further processing."

ERASE

support@mdmrehab.com

SAVE