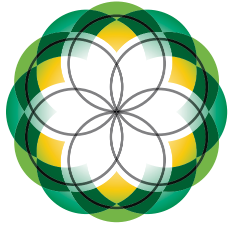


New Paradigm physical therapy

General Medical History

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**

PATIENT INFORMATION

Name: ______________________ LAST FIRST MIDDLE **DOB:** __________ **Today's Date:** __________

Briefly describe your condition ______________________

When did your condition begin? ______________________

When was your most recent doctor's appointment? ______________________

Is your condition a result of an injury such as a fall or car accident? ☐ **NO** ☐ **YES**

Is your condition resulting in a workmen's compensation claim? ☐ **NO** ☐ **YES**

If yes for either, please explain: ______________________

Is a lawyer involved? ☐ **NO** ☐ **YES**

Have you had this condition in the past? ☐ **NO** ☐ **YES**

Have you had any other treatment or evaluation for this condition (currently or previously)? ☐ **NO** ☐ **YES**

If yes, please check: ☐ **Surgery** ☐ **Chiropractic care** ☐ **CT scan** ☐ **MRI** ☐ **Injections** ☐ **X-Rays** ☐ **EMG/NCV** ☐ **Medications**

Other: ______________________

Have you had physical therapy for this or any other condition in the last year? ☐ **NO** ☐ **YES**

If yes, please list approximate dates and location of services: ______________________

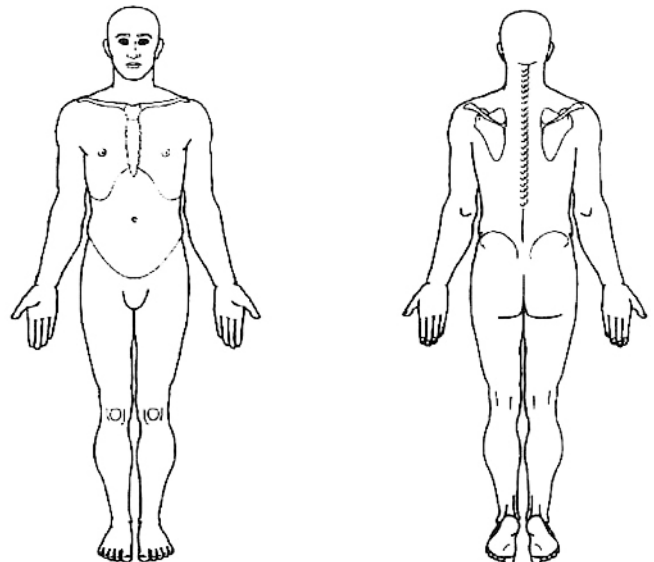
What are your goals for physical therapy? ______________________

Locate on the drawings any of the following sensations which apply:

Pain = X X X X X

Stiffness = * * * * *

Numbness/Tingling = O O O O O



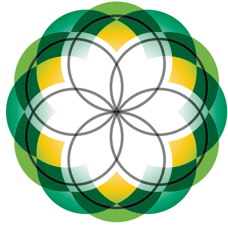
Rate your average discomfort on the scale below

0 **5** **10**

(No pain) (Severe pain)

What activities are you unable to perform because of your condition?

____



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PATIENT INFORMATION CONTINUED

At the present time, how would you rate your overall general fitness: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Please check all conditions that you have, or have had in the past

Musculoskeletal

☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Lupus / SLE
☐ Fibromyalgia
☐ Osteoporosis
☐ Bulging Disc
☐ Leg Cramps/Restless Legs
☐ Jaw Pain / TMJ
☐ Implanted devices
☐ Use of cane or walker
☐ Gout
Other: ____________

Psychological

☐ Depression
☐ Anxiety
☐ Bipolar disorder
☐ Schizophrenia
Other: ____________

Skin

☐ Skin allergies
☐ Eczema
☐ Rashes
☐ Psoriasis
Other: ____________

Nervous System

☐ Stroke / TIA
☐ Polio
☐ Parkinson's disease
☐ Multiple Sclerosis
☐ Epilepsy / Seizures
☐ Headaches / Migraines
☐ Concussion / TBI
☐ Numbness or Tingling
Other: ____________

Urinary

☐ Kidney Dysfunction
☐ Bladder Dysfunction
Other: ____________

Cardiovascular

☐ Heart Attack
☐ Heart Surgery
☐ Heart Arrhythmia
☐ Pacemaker
☐ High Cholesterol
☐ Blood Clots / Phlebitis
☐ Anemia
☐ High Blood Pressure
☐ Asthma / SOB
☐ COPD
Other: ____________

Infectious Disease

☐ TB
☐ Hepatitis
☐ Influenza
☐ Shingles
☐ Night sweats / fevers
Other: ____________

Digestion

☐ Irritable Bowel
☐ Liver Dysfunction
☐ Reflux disease
☐ Hernia
Other: ____________

Endocrine

☐ Diabetes
☐ Thyroid Dysfunction
Other: ____________

Cancer

Type of Cancer: ____________________

Date of Diagnosis: ____________ **Treatments:** ____________

Please list all current prescription medications that you are taking for any condition: ____________________

____

Please list all prior surgeries: ____________________

Please list all allergies: ____________________

Are you currently pregnant? ☐ **NO** ☐ **YES** **Do you currently smoke?** ☐ **NO** ☐ **YES**

Anything else you would like me to know: ____________________

____

Patient's Signature