NEW PATIENT INFORMATION

Name: ______________________________ Date: ______________________

If patient is under 18 yrs old-Guardian or Guarantor: ______________________________

Address ______________________ City ______________ State ______ Zip __________

Patient SS#: ______________ Birthdate: __________ Age ____ Height _____ Weight ____ Sex ____

Phone # (____) ______________ Work # (____) ____________ Cell # (____) ______________

WOULD YOU LIKE TO RECEIVE APPT NOTIFICATIONS BY EMAIL OR TEXT?

CIRCLE ONE: NO THANKS EMAIL TEXT (put cell # above-text message charges may apply)

EMAIL ADDRESS: ____

Referring Physician: ______________________ Date last seen: ______________________

Employer ______________________ Address ______________________________

Emergency Contact ______________________ Phone # (____) ______________________

Have you received PT or Chiropractic care this year? ☐ Yes ☐ No Where? ______________________

How did you choose Pro-Active Therapy? ☐Doctor ☐Friend ☐Self choice ☐ Advertisement

Name of person who referred you: ______________________________

I request that payment from my insurance carrier be made to me or on my behalf to "ProActive Therapy" for any services furnished to me by ProActive Therapy. I understand my signature, requests that payment be made and authorizes release of medical information necessary to pay all claims for services rendered. I authorize any treatment performed by ProActive Therapy.

Please sign: ______________________________ **Date:** ______________________

Guardian signature if patient under 18: ______________________________________

Primary Responsible Party, please check box

☐ Health Insurance: Name of insurance: ______________________ ID#: ______________

☐ Workers Comp: Name of Insurance: ______________________ Employer: ______________

☐ Auto accident: Name of Insurance: ______________________________________

☐ Self pay

The following questions are being asked to fulfill our commitment to protect your privacy (please check all boxes that apply):

☐ 1. Is there anyone other than you that we can discuss your medical information? ☐ Yes ☐ No
Name: ______________________________

☐ 2. May we contact you by phone to confirm appointments, and/or billing information?

Which do you prefer ☐Home Phone ☐Work Phone ☐Cell Phone

☐ 3. If you are unavailable at work may we leave a message in voice mail or with person answering the phone?

☐ Yes ☐ No **(If we have permission to leave a message we will identify ourselves as well as what office we are from.)**

☐ 4. Upon request may we fax your health and billing information? ☐ Yes ☐ No

Acknowledgement of Reciept of Notice of Privacy Practices I, ______________________, have received the Notice of Privacy Practices from ProActive Therapy. Sign: ______________________ Date ______

Medical History: Please check box if you have any of the following medical conditions:

☐ Allergies	☐ Chemical Dependency	☐ Gallbladder Problems	☐ Parkinson's
☐ Anemia	☐ Circulation Problems	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Anxiety	☐ Currently Pregnant	☐ High Blood Pressure	☐ Seizures
☐ Arthritis	☐ Depression	☐ Incontinence	☐ Speech Problems
☐ Asthma	☐ Diabetes	☐ Kidney Problems	☐ Strokes
☐ Cancer	☐ Dizzy Spells	☐ Metal Implants	☐ Thyroid Disease
☐ Cardiac Conditions	☐ Emphysema/Bronchitis	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Cardiac Pacemaker	☐ Fractures	☐ Osteoporosis	☐ Vision Problems

Describe any other conditions or precautions:

____

____

____

Fall History:

Have you had an injury as a result of a fall in the past year? ☐ Yes ☐ No

Two or more falls in the last year? ☐ Yes ☐ No

Surgical History:

Body Region(s): ____

Surgery Type(s): ____

Approximate Date(s): ______________________________________

Medications: Please specify drug, dosage, and reason taking

____

____

____

____

Drug or Substance Allergies: __________________________________

Social History and Living Conditions:

Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Tobacco Use:	☐ Never ☐ Quit/When? ________ ☐ Current Smoker/packs per day? ______
Alcohol Use:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Drug Use:	☐ Never ☐ Type and frequency: ____________________
House:	☐ Single story ☐ Multiple levels
Steps:	☐ Steps to enter house/work ☐ Steps in house/work Approximate number? ________
Drive Car:	☐ Never ☐ Rarely ☐ Daily
Living arrangement:	☐ Live with someone ☐ Live alone

History of Present Injury/Illness:

Please explain your current problem: ______________________________

Where is your problem located? ☐ Right ☐ Left ☐ Both Specify Location: ______________

When did your problem start? ______________________________

How did it start? ______________________________

Was it work related? ☐ Yes ☐ No Do you have pain? ☐ Yes ☐ No

Severity: (0 = no pain 10 = worst imaginable pain): ______

What kind of pain? ☐ Throbbing ☐ Sharp ☐ Radiating ☐ Dull Ache ☐ Soreness ☐ Burning ☐ Tingling

When? ☐ Sudden ☐ Constant ☐ Comes and goes ☐ With movement only ☐ Sleep

What makes it worse? ☐ Walking ☐ Running ☐ Standing ☐ Getting up ☐ Stairs ☐ Sitting
☐ Gripping ☐ Reaching overhead

What else do you experience? ☐ Swelling ☐ Grinding ☐ Giving way ☐ Catching ☐ Popping
☐ Locking ☐ Sleeping Problems

Does the condition affect ability to work? ☐ Yes ☐ No

How? ______________________________

Occupation: ______________________ ☐ Medical Leave ☐ Light Duty ☐ Full Duty

Does it affect your everyday living/sports/hobbies? ☐ Yes ☐ No

How? ______________________________

Have you previously had this or a similar problem? ☐ Yes ☐ No

Did you improve? ☐ Yes ☐ No

Why do you think? ______________________________

What previous treatments or surgery have you received for this problem? ______________

Have you previously seen someone for this current problem? ☐ MD ☐ Chiropractor ☐ PT/OT

Who? ______________

Have you had any of the following? ☐ X-ray ☐ MRI ☐ Bone Scan ☐ CT

When? ______________ Where? ______________

Do you have copies or reports? ☐ Yes ☐ No

Patient Statement:

To the best of my knowledge, the above information is accurate and complete.

Please print your name: ______________________

Signature (Parent/Guardian): ______________________