



SPORT AND SPINE REHAB

PATIENT INFORMATION			
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth Date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: - -
Home Phone: () -	Alt. Phone (Cell, Pager): () -	Spouse:	
Chose Clinic Because:	<input type="checkbox"/> Dr. <input type="checkbox"/> Insurance <input type="checkbox"/> Family/Friend <input type="checkbox"/> Former Patient <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other		
Whom may we thank for your referral?			
WORK INFORMATION			
Employer:	Work Phone () -	Ext.	
Occupation:	Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed		
CARE PROVIDER INFORMATION			
Referring Physician:	Referring Physician Phone: () -		
Primary Physician/PCP:	Primary Physician/PCP Phone: () -		
AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INSURANCE INFO ALSO)			
Insurance Name: <input type="checkbox"/> Auto:	<input type="checkbox"/> Workers Compensation:		
Adjuster/Claim Manager:	Phone:	Ext:	
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: () -	
Address:	City:	State:	Zip:
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:	Home Phone:	Work Phone:	

I authorize my insurance benefits be paid directly to Central Missouri Physical Therapy and I understand that I am financially responsible for any balance. I also authorize Central Missouri Physical Therapy to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE

DATE

PATIENT MEDICAL HISTORY

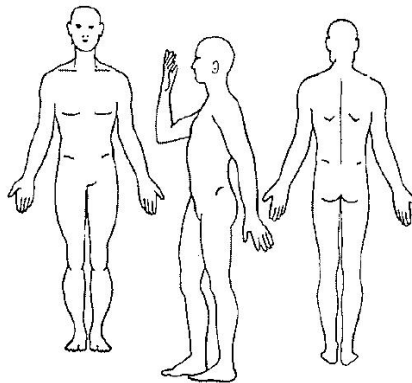
HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?								
	YES	NO		YES	NO		YES	NO
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
CHF	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently pregnant? Yes No

Do you have a pacemaker? Yes No

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED, INCLUDING THE APPROXIMATE DATE AND REASON FOR THE SURGERY OR HOSPITALIZATION:		
Date	Surgery/Hospitalization	Reason

Please list the prescription medication(s) you are currently taking, including pills, injections, and/or skin patches:



Please indicate areas of pain and discomfort (on the figures above) using the following symbols:

/// = Pain | *** = Numbness, no feeling at all | +++ = Tingling, asleep, abnormal feeling

Please rate your pain on a scale of 0 to 10: _____ / 10 At Highest _____ / 10 At Lowest

