

Patient History

Social and Family History

Name: _____ Marital Status: _____ Age: _____ Occupation: _____

Are you currently working at your usual job? _____ Is it Modified Duty? : _____ Full/Part Time: _____

If not working, is it due to the problem you are being seen for today? Yes No

Patient living with: Self Both Parents Spouse Mother Father Other

Do you have a family history of the following? Heart Trouble Cancer Rheumatoid Arthritis Osteoporosis

Alcohol/Drug Use: Cigarettes Packs/Day _____ Cigar/Pipe Snuff/Dip

Drugs Amount & Type _____ Alcohol Glasses or Drinks/Week _____

Current Problem

1 List the area of the problem _____

2. Right Handed Left Handed

3 How did this problem begin? Lifting Twisting Falling Car accident Unknown Other

4 Date of injury or when the problem first occurred: _____ Was the onset Gradual or Sudden

If you have had this problem for a long time when did it recently become worse? _____

5 Have you been hospitalized for this problem? _____ Dates: _____

6. Have you had any of the following tests for this condition? Dates: _____

X-rays MRI CAT Scan Bone Scan None Other: _____

7. Do you currently have the flu or experiencing flu like symptoms? Yes No Explain: _____

Medical History

1. Have you ever been diagnosed as having any of the following? Check where applicable.

<input type="checkbox"/> Seizures	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> GI Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sedentary Life Style	<input type="checkbox"/> Other Arthritic Conditions
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> Heart Troubles	<input type="checkbox"/> Stroke	<input type="checkbox"/> HIV

Other: _____

2. Are you currently or in the past 6 months being seen by any of the following? Check where applicable.

<input type="checkbox"/> Speech Therapist	<input type="checkbox"/> Dentist	<input type="checkbox"/> Psychiatrist/Psychologist	<input type="checkbox"/> Osteopath	<input type="checkbox"/> Physical/Occupational Therapist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Medical Doctor	For what reasons: _____		

3 Have you ever had a fracture or dislocation? No Yes If yes, what body part? _____

4. Are you pregnant or is there the possibility that you are pregnant? Yes No

5. Do you have any of the following metals or plastics in your body?

<input type="checkbox"/> Rods	<input type="checkbox"/> Pins	<input type="checkbox"/> Plates	<input type="checkbox"/> Metal from gunshot	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Staples	<input type="checkbox"/> Screws
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Where: _____

Primary Care Doctor: _____

List past surgical procedures or hospitalizations and dates: _____

Current medications being taken: _____

List known drug allergies & reactions: _____

I, _____, hereby give my permission for the staff to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. I hereby assign all disability, surgical, medical and major medical insurance benefits to Northview Associates and/or Appalachian Physical Therapy for services rendered unless prior arrangements have been made. I hereby authorize the release of any medical information necessary to process this claim, the ability to obtain any information needed for my medical care, and also authorize payment of medical benefits to Northview Associates and/or Appalachian Physical Therapy. A photocopy of this authorization and assignment shall be considered as valid as the original. I understand that regardless of any insurance coverage I might have, I am personally responsible for ALL charges to this account.

Signature _____ Date _____

Reviewed By Clinician: _____ Date: _____

Reviewed By Doctor: _____ Date: _____