New Patient Introduction

Referring Doctor _____ Today's Date _____

Patient Information

Last Name _____ First Name _____ M.I. _____

Mailing Address _____ APT # _____

City _____ State _____ Zip _____

Phone (home)_____ (cell)_____

Sex (circle) Male Female Date of Birth _____ Age _____ SS# _____

Spouse Name _____ Spouse's Phone _____

Emergency Contact _____ Emergency Contact Phone _____

Is this injury / episode (circle) Personal Work related Motor Vehicle Accident

Insurance

Primary Company _____ Name of Insured _____

Relationship to Insured _____ Group # _____ ID # _____

Insured Date of Birth _____

Secondary Company _____ Name of Insured _____

Relationship to Insured _____ Group # _____ ID # _____

Insured Date of Birth _____

Employed (circle) Yes No If Yes, where _____

School (circle) Yes No If Yes, where _____

Do you have an Attorney (circle) Yes No If yes, who _____

Would you like to provide your e-mail address so that we might periodically send you informational on

various musculoskeletal issues and treatment plans? _____@_____

Date of Injury/Surgery Date _____ **Surgery Type**_____

Present Symptoms

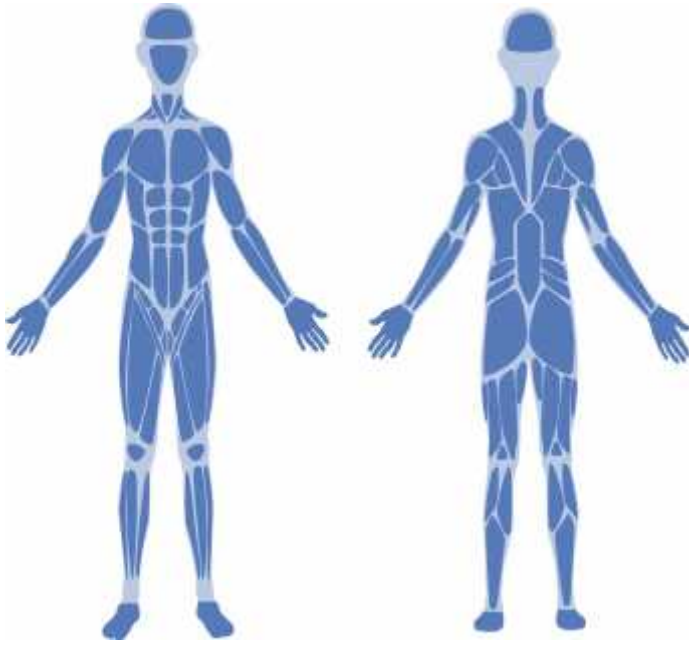
- PAIN Location _____

  How Often _____

- NUMBNESS / TINGLING Location _____

  How Often _____

- Please indicate on the figure below where your pain is and what type (example – achy, tight or shooting)



Please draw on the body where you feel pain or other symptoms. Use the key below.

A = ache	S = sharp
D = dull	TG = tingling
TT = tight	N = numbness
W = weak	↑↓ = shooting pain

Please circle the number which best describes your pain level.

Now (least) 1 2 3 4 5 6 7 8 9 10 (most)

Best (least) 1 2 3 4 5 6 7 8 9 10 (most)

Worst (least) 1 2 3 4 5 6 7 8 9 10 (most)

What activities does this problem **prevent** you from doing?

_____

_____

Medical History (please check if yes)

- ☐ High blood pressure
- ☐ Arthritis
- ☐ Diabetes
- ☐ Stroke
- ☐ Pacemaker
- ☐ Nerve Disorder
- ☐ Seizures
- ☐ Dizziness
- ☐ Heart problems
- ☐ Cancer
- ☐ Pregnant
- ☐ Surgery _____
- ☐ Metal Implant (where?) _____
- ☐ Other _____

Medications	For What

Allergies:

CONSENT FOR TREATMENT

I hereby consent to the procedures which may be performed during therapy sessions rendered to the patient under the general and special instruction of the patient's physician or therapist. Patient understands he/she has the right to refuse treatment, or any part of treatment at any time. By signing, you also acknowledge you have read, understand and have received a copy of the Notice of Privacy Practices.

I hereby authorize my insurance benefits to be paid directly to Yosemite Physical Therapy, Inc., and that I am financially responsible for non-covered services**, including a $20 fee for no-showed appointments, or appointments that are cancelled less than 24 hours in advance** (emergencies and sickness excluded). I also authorize Yosemite Physical Therapy to release any information to process this claim.

SIGNED:_____DATE_____