

Full Reps Physical Therapy

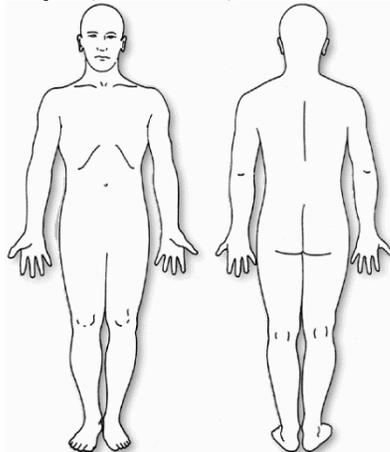
New Patient Information Sheet

Please help us make the best use of our time together by completing this prior to your appointment.

Name:			Today's date:		
	Last Name	First Name			
Address:					
City / State / ZIP:					
Phone #	MOBILE		HOME		WORK
DOB://			Age:		
Email:					
Occupation:			Employer:		
Emergency Contact	Name:		Phone:		
Primary Care Physician	Name:				
Specialist Physician	Name:				

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?	<p>Please shade in areas where you have pain, discomfort, or tension.</p> 
Secondary concern/problem?	
As a result, I am now having difficulty with:	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	
When did your symptom(s) begin? (Date):	

Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.	At its worst	
	At its best	
	At present	
	Night (sleeping)	

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At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
<input type="checkbox"/>	Massage	<input type="checkbox"/>	Bodywork	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Myofascial Release	<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Neurological problems	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Epilepsy / seizures	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Malignancy	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Broken bones (fracture)	<input type="checkbox"/>	Metal implants	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Heart disease / pacemaker	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Others (explain below)		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

List all the Tasks / Activities that you have difficulty performing and your estimated tolerance (minutes/hours). If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

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Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

INFORMED CONSENT

I understand that Full Reps Physical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Full Reps Physical Therapy to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I hereby certify that all the above information is true to the best of my knowledge.

FINANCIAL POLICY

Bob Gorinski, PT is not a preferred provider for insurance companies. Instead, Full Reps Physical Therapy, LLC is a cash-based practice. By not having a preferred

