Woodstown Physical Therapy and Sports Rehab

Are you a previous patient? □ Y □ N

Name _____ **DOB** _____ **(AGE)** _____

SS# _____ **Sex: □ M □ F**

Home Address _____ **City/State** _____ **Zip**_____

Phone (Home) _____ **Phone (Cell)** _____

Emergency Contact _____ Relationship _____ Phone_____

Your E-mail _____ Date of Injury or onset: _____

Is your injury a result of a motor vehicle accident or work related injury: _____

EMPLOYMENT/SCHOOL (Circle appropriate one)

Patient Employer/School _____ Occupation _____

Emp Address _____ City/State _____ Zip _____

Phone (Work) _____

SPOUSE'S/PARENT EMPLOYMENT (Circle appropriate one)

Spouse/Parent Name _____ Spouse/Parent Date of Birth _____

Employer _____ Occupation _____Phone_____

Employer Address_____ City/State _____ Zip _____

APPOINTMENT REMINDERS

Would you like to receive appointment reminders? If Yes, please advise how you would prefer to be reminded:

☐ Text message: (_____) _____ ☐ Email: _____

☐ Telephone Call: (_____) _____

INFORMATION RELEASE AND AUTHORIZATION

I hereby consent to the release and disclosure of my personal health information to the follow: (please list any individuals whom we have permission to discuss you care and appointments with) _____

_____

SIGNATURE: _____ **Date:** _____

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Medical History Questionnaire

Patient Name		**Date of Birth**		**Age**	
Height		**Current Weight**			
Reason for Therapy		**Date of Injury or Onset**			

Are you currently receiving any other care for the condition mentioned above? ☐ No ☐ Yes	If yes list:
Have you ever received therapy in the past six months for the condition mentioned above? ☐ No ☐ Yes	If so, when?
Previous Treatment Received From (check any that apply): ☐ Physician ☐ Athletic Trainer ☐ Physical Therapy ☐ Chiropractor	Previous Treatment: ☐ Successful ☐ Unsuccessful
Have you received therapy services for other problems/conditions during 2023 ☐ No ☐ Yes If yes, please list:	
Tobacco Use: ☐ No ☐ Yes If Yes, how many packs/cans a week:	
Do you now or have you ever had any of the following?	

Condition	Yes	No
Arthritis	☐	☐
Osteoporosis	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Pacemaker	☐	☐
Vascular Disease	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Chronic Cough	☐	☐
Fainting Spells	☐	☐
Tuberculosis	☐	☐

Condition	Yes	No
Diabetes	☐	☐
Anemia	☐	☐
Hypersensitivity to Heat/cold	☐	☐
Swelling in Ankles	☐	☐
Deep Vein Thrombosis (DVT)	☐	☐
Seizures/ Epilepsy	☐	☐
Metal in Body or Surgical Implants	☐	☐
Cancer/ Tumor	☐	☐
Recent Weight Loss/ or Gain	☐	☐
Current Infection(s)	☐	☐
Hepatitis	☐	☐

Condition	Yes	No
Thyroid Problems	☐	☐
Headaches	☐	☐
Head Injury/ Concussion	☐	☐
Hernia	☐	☐
Kidney/Bladder Problems	☐	☐
Previous Fractures	☐	☐
Previous Surgeries	☐	☐
Hearing Loss	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Substance Abuse	☐	☐
Pregnant	☐	☐

Do you have any allergies? ☐ No ☐ Yes If yes, please list allergies:	
Are you presently taking any medications? ☐ No ☐ Yes If yes, please list medications and dosage/frequency:	
At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor	
The information is correct to the best of my knowledge.	
X	
Patient/Parent/ Guardian Signature	Date

Please mark an X to indicate the areas where you feel pain, swelling, numbness, or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.