

CLINIC _____

NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date: _____

Name (First) _____ (Last) _____ (M.I.) _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Mobil Phone (____) _____

Social Security _____ Birth Date _____ Age ____ Sex: M / F

Drivers Lic # _____ Email Address _____

Status Married / Single / Divorced / Separated / Widowed Student No / Full-time / Part-time

Emergency Contact _____ Telephone # (____) _____

Referring Physician _____ Telephone # (____) _____

Referring Dr. Address _____

Who may we thank for your referral other than your Doctor? _____

Employer _____ Employment Full / Part-time / Not Working / Retired

Address _____ Telephone # (____) _____

Injury Type Work Auto Home Other _____ Injury Date _____

Attorney Involved Yes / No Attorney name _____

Address _____ Telephone # (____) _____

Primary Insurance _____

Insured Name _____ Social Sec# _____ D.O.B. _____

Secondary Insurance _____

Insured Name _____ Social Sec# _____ D.O.B. _____

Third Insurance _____

Insured Name _____ Social Sec# _____ D.O.B. _____

Have had any prior Chiropractic, Speech, Occupational or Physical Therapy? Yes / No How many visits _____

Patient Signature: _____ Date: _____

(PEAK PERFORMANCE STAFF USE ONLY)

Eval Date: _____

Financial Class: WC PRVT MC CASH LIEN HMO MCD

Therapist: _____

PEAK PERFORMANCE

MEDICAL HISTORY

Patient Name _____ Age _____

Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition _____

Have you received chiropractic treatment this year? Yes / No

Have you had any imaging performed:

- X-Ray
- MRI
- CT Scan
- Doppler
- Ultrasound

Have you recently noted:

- Weight Loss /Gain
- Weakness
- Pregnant / IUD
- Pain At Night
- Nausea / Vomiting
- Fever / Chills / Sweats
- Headaches
- Cramps In Legs When Walking
- Fatigue
- Numbness / Tingling
- Change In Vision Or Hearing
- Insomnia

Do you have now or have you ever had any of the following?

- Surgeries
- Sprains / Strains
- Pacemaker
- Heart Problems
- Circulation Problems / Clots
- Easy Bruising / Bleeding
- Indigestion / Heartburn
- Loss of Consciousness
- Diabetes
- Cancer
- Asthma / Breathing Problems
- Leg / Ankle Swelling
- Fainting
- Fractures
- Blood Pressure Problems
- Motor Vehicle Accident
- Lung Disease
- Urinary Problems / Infections
- Allergies / Skin Sensitivity

Any previous injury that may affect current care _____

Explain & give approximate dates for any items indicated above _____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

What are your physical or fitness goals: _____

Is there anything else you would like to include or ask your physical therapist? _____

Patient or Personal Representative Signature

Date

