New Patient Information

Name: _____ Date: _____

Address: _____ ODL: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Social Security No: _____

Date of Birth: _____ Employer/Occupation: _____

In case of emergency, please contact:

Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Accident Information: Date of Accident _____ Time of Accident _____

Were you the ❑ Driver ❑ Front Passenger ❑ Rear Passenger ❑ Pedestrian

Please describe the accident in your own words: _____

_____

_____

Make and model of the vehicle you were in _____

Were you wearing a seatbelt? ❑ Yes ❑ No If so, what type? ❑ Shoulder ❑ Lap

Was the vehicle equipped with airbags? ❑ Yes ❑ No If yes, did they inflate properly? ❑ Yes ❑ No

Did your vehicle have a headrest? ❑ Yes ❑ No If yes, what position was it in? ❑ Low ❑ Mid ❑ High

Did your car impact another car? ❑ Yes ❑ No Did your car impact a structure? ❑ Yes ❑ No

Did any part of your body strike anything in the vehicle? ❑ No ❑ Yes _____

Was the impact from the ❑ Front ❑ Rear ❑ Left ❑ Right ❑ Other _____

At the time of impact where were you looking? _____

Were both hands on the steering wheel? ❑ Yes ❑ No If no, which was on the wheel? ❑ L ❑ R

Was your foot on the brake? ❑ Yes ❑ No If yes, which foot was on the brake? ❑ L ❑ R

Were you ❑ Surprised by the impact ❑ Braced for the impact

What speed were you travelling? _____ What speed was the other car travelling? _____

Driving conditions: ❑ Dry ❑ Wet ❑ Icy ❑ Other

Client Condition

Were you unconscious immediately after the accident? ❑ Yes ❑ No

Please describe how you felt immediately after the accident _____

_____

Treatment

Did you go the the hospital (urgent care)? ❑ Yes ❑ No / Were X-rays taken? ❑ Yes ❑ No / MRI? ❑ Yes ❑ No

When did you go? ❑ Immediately after the accident ❑ The next day ❑ 2 days or more after _____

Diagnosis_____

Treatment received_____

Symptoms and/or Injuries

Have you been able to work since the injury? ❑ Yes ❑ No

Has this injury influenced your work performance? ❑ Yes ❑ No If yes, how?_____

_____

If you have had any of the following symptoms since your injury please check the appropriate box:

❑ Aching	❑ Difficulty eliminating	❑ Fatigue	❑ Radiating Sensation	❑ Stress
❑ Blurred vision	❑ Discomfort	❑ Headaches	❑ Sharp pain	❑ Swelling
❑ Breathing difficulty	❑ Disorientation	❑ Irritability	❑ Shooting pain	❑ Tenderness
❑ Burning sensation	❑ Dizziness	❑ Muscle Spasms	❑ Sleep difficulty	❑ Throbbing
❑ Coughing	❑ Dull pain	❑ Nausea	❑ Sneezing	❑ Tightness
❑ Cracking noises	❑ Ear buzzing	❑ Numbness	❑ Soreness	❑ Tingling
❑ Cramping	❑ Ear ringing	❑ Popping sounds	❑ Stiffness	❑ Weakness
❑ Difficulty arising				

Symptoms are in the:

❑ Head	❑ Jaw	❑ Neck	❑ Wrists	❑ Hands
❑ Hips	❑ Thighs	❑ Legs	❑ Ankles	❑ Feet
❑ Chest	❑ Shoulders	❑ Buttocks		❑ Abdomen
Back:	❑ Upper	❑ Middle		❑ Lower

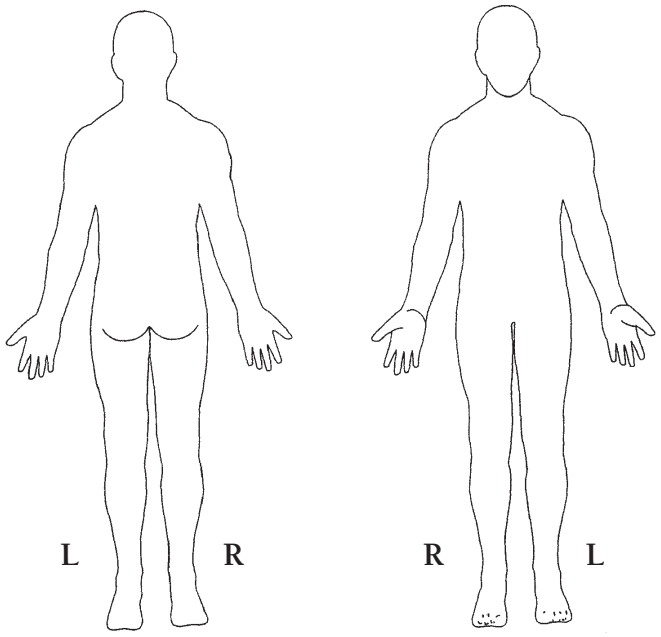
Symptoms are worsened by:

❑ Driving	❑ Exercise	❑ Lifting	❑ Bending
❑ Cold	❑ Work	❑ Standing	❑ Sitting
❑ Twisting	❑ Walking	❑ Daily Activity	
❑ Other _____			

Symptoms are eased by:

❑ Lying Down	❑ Resting	❑ Hot Packs	❑ Cold Packs
❑ Medication	❑ Massage	❑ Activity	
❑ Other _____			

Using the scale below, mark the affected areas with the appropriate numbers.



How to rate your symptoms on a pain scale of 1 to 10

10 Your pain is **intense, constant**, greatly restricts your activities, and it is impossible to go more than **5** minutes without awareness of the pain.

9 Your pain is **intense, constant**, greatly restricts your activities, but you can forget about the pain for up to **15** minutes at a time.

8 The pain is **significant**, moderately **intense** at times, but **not constant**. Most activities are affected, and you think about it once or twice an hour.

7 The pain is **significant** at times, but **never intense** and **not constant**. Most activities are affected, and you think about it once or twice an hour.

6 The pain is **moderate**, yet too frequent to ignore. **Some activities are affected**. Hours can go by without being aware of the pain.

5 The pain is **moderate**, yet too frequent to ignore. **Almost no activities are affected**. Hours can go by without being aware of the pain.

4 The pain is little more than a **nuisance**, and you go through your whole day **frequently aware**, but not really affected by it.

3 The pain is little more than a **nuisance**, your awareness of the pain may be **absent for a whole day** at a time, and you are never affected by it.

2 At it's worst, the pain is best described as **uncomfortable**. Days can go by without being aware of it.

1 At it's worst, the pain is best described as **uncomfortable**. Your symptoms **do not recur more frequently than once a week.**

Medical History

Please check Yes or No to the following questions, and explain in spaces provided:

YES NO

❑ ❑ Are you wearing any medical devices? ❑ Contacts, ❑ Dentures, ❑ Hearing Aid, ❑ Other _____

❑ ❑ Do you suffer from any of the following?

❑ Skin disorders: ❑ Rash, ❑ Yeast, ❑ Fungus, ❑ Psoriasis, ❑ Infection, ❑ Other _____

❑ Allergies: ❑ Oils, ❑ Nuts, ❑ Skin care ingredients, ❑ Other _____

❑ ❑ Are you under the care of a physician for any reason? Please explain _____

❑ ❑ Are you taking any medications? If yes, when was your last dose?_____

❑ ❑ Any recent/current illnesses? ❑ Infectious, ❑ Viral, ❑ Bacterial, ❑ Other _____

❑ ❑ Have you ever been diagnosed with any of the following conditions?

❑ Arthritis. Type and location(s) _____

❑ High blood pressure, ❑ Low blood pressure, ❑ Aneurism, ❑ Embolism, ❑ Other_____

❑ Heart Disease _____

❑ Diabetes: ❑ Type I, ❑ Type II (Adult Onset), ❑ Other _____

❑ Cancer. Type and location(s) _____

❑ Spinal condition: ❑ Scoliosis, ❑ Osteoporosis, ❑ Other _____

❑ Other medical condition(s)_____

Date(s) of diagnosis of any of the above conditions _____

❑ ❑ Have you ever had surgery? Affected area of the body_____ Date/Year(s) _____

❑ ❑ Do you have any needs that require special attention? _____

❑ ❑ Do you have any questions before we get started? _____

Other:_____

_____

For Women Only

YES NO Menstrual: ❑ Pain/Cramping ❑ Irregularity ❑ Other_____

❑ ❑ Are you now pregnant? What trimester? _____ Any problems?_____

General Understanding

I understand that Orthopedic Massage Therapy and other related health care services from this office are not in any way to be used instead of or in place of consulting a Physician for diagnosis and treatment of any physical symptoms, but to be used in conjunction with, or on the advice, referral, or prescription of, my Physician(s). _____ Please initial.

CANCELLATION POLICY

Your scheduled appointments are reserved exclusively for you. We take pride in our commitment to you in keeping all appointments as scheduled. Please call your therapist as soon as you know you cannot keep an appointment. All missed appointments, and cancellations made after 5pm the business day preceding your scheduled appointment, will be billed for the time reserved. You are responsible for these charges, and payment will be expected by the time of your next visit. If you miss two appointments without notice, your treatment will be terminated. Your courtesy and cooperation in enabling us to provide the best possible care for all of our physicians' patients is appreciated. _____ Please initial.

By my signature, I verify that all information provided on the previous 3 pages is true and correct to the best of my knowledge. I promise to keep my health care providers updated on any changes in my health and residence. I authorize payment of insurance benefits billed for services rendered by this office to be paid directly to this office for said services. I authorize this office to release any information in its possession requested by my insurance company for the purpose of processing claims.

_____ Date _____

Patient (or Guardian's) **Signature**