PATIENT INFORMATION

Name: ______________________________ DOB: ______________ Gender: ☐ M/ ☐ F

Address: ______________________________ City: ______________ Zip: __________

Phone: ______________ What would you prefer to be called: ______________

SS#: ______________ E-Mail Address: ______________________________

Occupation ______________ Working? ☐ Y / ☐ N Date Last Worked ______________

If patient is a minor, please list parent or guardian's name & address:

____

____

Referring Physician: ______________________________ Next Appt. Date: __________

Primary Physician: ____

Chief Complaint/Injury ____

Is this a recurrent injury? ☐ Yes ☐ No

Degree of Pain (circle one) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: ☐ Dull ☐ Sharp ☐ Constant ☐ Intermittent ☐ Localized ☐ Radiating

List all surgeries: ____

____

Previous injuries: ____

____

Other Medical Conditions: ____

____

Are you currently being treated by anyone other than your physician for this problem?
☐ Yes ☐ No

Do you have a Cardiac History? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

List of current medications: ____

____

____

Allergies: ☐ Yes ☐ No If yes, to what? ______________________________

Past Physical Therapy: (What, When & Where) ______________________________

In case of an emergency, provide a name and phone number of contact person:

____

How did you hear about Orthosports? ______________________________

______________________________ ______________________________

Patient signature Parent / Guardian signature
(for minor patients)