ORTHO SPORT
PHYSICAL THERAPY, INC.

Date:____/_____/____

Patient Information:

Name: _____ Date of Birth: ____/____/_____

Address: _____
Street City State Zip Code

Home Phone:_____ Cell Phone: _____

Email: _____

Occupation: _____ Height: _____ Weight: _____

Dominant hand: **L or R** Sex: **M or F** Marital Status: **M S D W** # of Children: _____

If under 18 years of age, Parent or Guardian: _____

Emergency Contact: _____Emergency Contact Phone Number: _____

How did you hear about Ortho Sport Physical Therapy, Inc.: _____

Injury Information:

Diagnosis: _____

Is this a new injury or a chronic issue?: _____ When did you start experiencing symptoms?: _____

Injury/Surgery Date: _____ Cause of injury?:_____

Primary Care Doctor: _____

Referring Physician: _____

Insurance Information:

Insurance Company: _____ Member ID:_____

Policy Holder's Name: _____ Policy Holder DOB: _____/_____/_____

Have you ever had physical therapy before? Y or N If so, when?: _____

For this diagnosis or a different one?: _____

If applicable, please choose below AND provide ALL information:

☐ **Auto Insurance** ☐**Worker's Compensation Insurance**

Claim Number: _____

Insurance Company: _____ Policy Holder: _____

Adjustor's Name: _____Adjustor's Phone: _____ext_____

Employer: _____

Employer Address: _____

Attorney Information:

Attorney Name: _____ Phone: _____

Address: _____ Fax: _____

(please see other side)

Personal History:

List sports/exercises/hobbies you are actively involved in: _____

_____

Related past injuries: _____

Have you had any other intervention for this problem i.e. Chiropractor, acupuncture, etc.?

_____

Is your problem getting better/worse or staying the same since it started? _____

_____

What is your goal for physical therapy? _____

Past Medical History

Please circle the answer and add any others, please include date of incident

Cancer	**Yes or No**	**_____**
Pregnant	**Yes or No**	**_____**
Heart Disease	**Yes or No**	**_____**
Pacemaker	**Yes or No**	**_____**
High Blood Pressure	**Yes or No**	**_____**
Diabetes	**Yes or No**	**_____**
Headaches	**Yes or No**	**_____**
Fainting	**Yes or No**	**_____**
Gastrointestinal Issues	**Yes or No**	**_____**
Arthritis	**Yes or No**	**_____**
Dizziness	**Yes or No**	**_____**

Other: _____

Please list any past surgeries or injuries: _____

Please list any allergies: _____

What medications are you currently taking? _____

_____

Do you have a follow up appointment with your doctor? YES / NO When: _____

The above information is true to the best of my knowledge.

Patient/Representative Signature: _____ **Date:** _____