CHAINWORK

Patient Name: _____ **DOB: _____ Sex: _____**

Address: _____

Mobile Phone: _____ **Work Phone: _____**

Email: _____

Emergency Contact: _____ **Relationship: _____**

Occupation: _____ **Are you presently working? ☐ Yes ☐ No**

Method of Payment: ☐ Self-pay ☐ Medicare

If you have Out-of-Network insurance benefits, will you be seeking reimbursement from provider?

☐ Yes ☐ No

Date of injury / onset: ___/___/___ **Date of next physician's visit: ___/___/___**

Have you ever had PT for current issue? **☐ Yes ☐ No**

Check which apply to your symptoms:

☐ athletic injury
☐ motor vehicle accident
☐ injury related to lifting
☐ cause unknown
☐ recurrence of previous injury
☐ work-related injury
☐ injury related to falling
☐ other: _____

Have you had a related surgery? **☐ Yes ☐ No**

Do you participate in a sport, exercise program or regular physical activity? ☐ Yes ☐ No

If yes, please describe: _____

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Do you have, or have you been diagnosed with any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Nausea/Vomiting	☐	☐
Chest / Angina	☐	☐	Liver Problems	☐	☐
High Blood Pressure	☐	☐	Smoker	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness	☐	☐
Kidney Issues	☐	☐	Recent Fracture	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Rheumatoid Arthritis	☐	☐
Stroke	☐	☐	Asthma/ Bronchitis	☐	☐
Other	☐	☐	HIV/AIDS	☐	☐

(If yes to any of the above, please briefly explain and provide approximate timeframe):

Past surgical history? ☐ Yes ☐ No

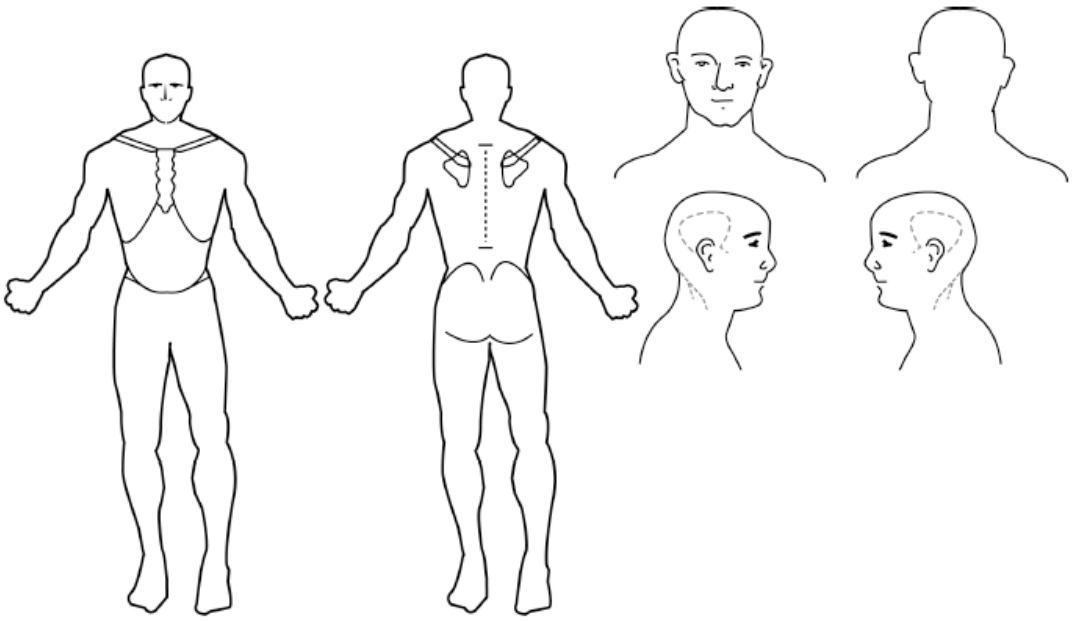
(If yes, please briefly explain and provide approximate date):

Currently taking medication/supplements? ☐ Yes ☐ No

(If yes, please list medication, condition, dosage, etc):

Is there any other information regarding your past medical history that we should know about?

Please identify symptom areas below:



If you are having pain, please rate the intensity of your pain on a scale of 0-10 (0 = no pain, 10 = worst pain ever) _____.

_____ ____/____/____

Patient/Guardian Signature **Date**

_____ ____/____/____

Therapist Signature **Date**