To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested in the following form. **If a question is not clear, please leave it blank and your therapist will assist you.** Thank you for choosing Synergy Studio.

Name: ______________________ Address: ______________________

Reason for Physical Therapy ______________________

Occupation: ______________________ Primary or Referring MD: ______________________

Date of Birth: __________ Daytime Phone: __________ Mobile Phone: __________

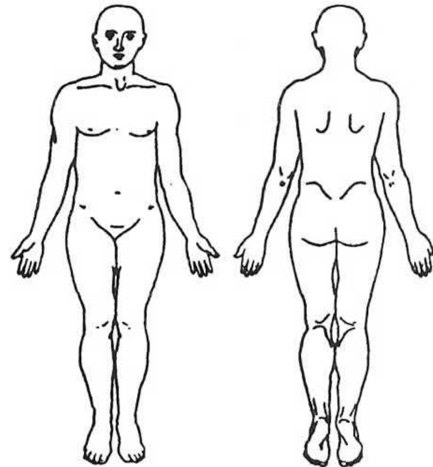
Email address: ______________________ How did you hear about us? ______________________

Please check any of the following health professionals whose care you are currently under.

___Medical Doctor ___Osteopath ___Chiropractor ___Dentist ___Psychiatrist/Psychologist

___Physical Therapist ___Occupational Therapist Other ______________________

Please indicate the **location** of your symptoms on the diagram to the right by shading in the area of symptoms.



Please indicate the **level of pain** on a scale of 0 to 10 with 0 representing no pain and 10 representing the level of pain that would make you seek emergency care

.

Pain in the last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Average pain the past week: 0 1 2 3 4 5 6 7 8 9 10

Date of onset of symptoms : ______________________

Brief description of symptoms: ______________________

How did your symptoms start?: ______________________

List your leisure activities: ______________________

Frequency of exercise: Daily 3 times weekly Once a week

YES NO Exercise provokes symptoms. When was the last time you exercised? __________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have you carried any pregnancies to term? YES NO If YES, how many: __________

Have you **recently** noted any of the following:

YES NO Weight loss/gain

YES NO Dizziness/lightheadedness

YES NO Weakness

YES NO Numbness or tingling

YES NO Nausea/Vomiting

YES NO Fatigue

YES NO Fever/chills/sweats

YES NO Vision changes (ie. new glasses)

Have you **ever** been diagnosed as having any of the following conditions?

YES NO Cancer If YES, what kind: ________________ Date diagnosed:________________

YES NO Heart Problems
YES NO Circulation Problems
YES NO Emphysema/Bronchitis
YES NO Thyroid Problems
YES NO Rheumatoid Arthritis
YES NO Osteoporosis/Osteopenia
YES NO Multiple Sclerosis
YES NO Kidney disease
YES NO Hepatitis
YES NO Stroke

YES NO High Blood Pressure
YES NO Asthma
YES NO Chemical Dependency (ie. alcoholism)
YES NO Diabetes If YES, Type 1 or 2
YES NO Other Arthritic Conditions
YES NO Urinary or Fecal Incontinence
YES NO Depression
YES NO Anemia
YES NO Tuberculosis
YES NO Epilepsy

Describe any illness diagnosed by a physician not in the list ________________________

Please list any surgeries or hospitalizations you have had in the past:

DATE	REASON FOR SURGERY/HOSPITALIZATION
1. ________	________________________
2. ________	________________________
3. ________	________________________

Please describe any **significant injuries** for which you have been treated (ie.sprains, fractures)

DATE	INJURY
1. ________	________________________
2. ________	________________________
3. ________	________________________

Has anyone in your immediate family (parents, siblings) ever been treated for the following?

YES NO Diabetes
YES NO Kidney Disease
YES NO Headaches

YES NO Cancer
YES NO Arthritis
YES NO Tuberculosis

YES NO Heart disease
YES NO Anemia
YES NO Mental Illness

Which of the following over the counter medications have you taken in the past week?

YES NO Aspirin
YES NO Laxatives
YES NO Antacids

YES NO Tylenol
YES NO Decongestants
YES NO Vitamins/ Mineral Supplements

YES NO Advil/Motrin/Ibuprofen
YES NO Antihistamines

YES NO Other including herbal/homeopathic ______________________________

Please list any prescription medications that you are currently taking:

____

____

ALLERGIES: List any medications you are allergic to:______________________

Are you latex sensitive? Yes No Any other allergies we should know about? ___________

YES NO Do you drink caffeinated beverages? If YES, how much caffeinated coffee or caffeine containing beverages do you drink per day?_________ How many days per week? _________

YES NO Do you drink alcoholic beverages? If YES, and one drink equals one beer or glass of wine, how much do you drink at an average sitting?______ How many days per week?_______

YES NO Do you smoke? If YES, How many packs of cigarettes do you smoke in a day?______

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you experienced little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home, has anyone hit you or tried to injure you in any way? YES NO

Patient Signature______________________________________ Date________________

Therapist Signature____________________________________ Date________________

Thank you for your cooperation in the completion of this form. You are welcome to add any further information that was not specifically requested above but you feel is important to share with the therapist in the space below.

Please fill out the form on the back of this page if you have requested to have your insurance company billed for your therapy through our billing service.

New Patient Information Sheet

Patient Information

Name :(First) ____________________ (MI) _____ (Last) ____________________

Date of Birth____________________ Age _____ Sex M F Marital Status: S M W D

Address: Street ____________________

City____________________ State ________ Zip ____________

Phone #: ______________ SS#: ______________ DL# ______________

Work #: ____________________ Employer: ____________________

Employer's Address: ____________________

Referring Physician: ____________________

If Student, School Name: ____________________

Insurance Information

Insurance Co: ____________________ Phone # ______________

Insurance Address: ____________________

Group # ____________________ Certificate/ID # ____________________

Insured's Name: ____________________ Relationship to Patient: Self Spouse Dependent

Insured's Employer: ____________________ Phone # ______________

Employer's Address: ____________________

Insured's SS # ____________________ Date of Birth: ______________ Sex: M F

I hereby assign, transfer, and set over to Synergy Studio all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: ____________________ Date: ______________