NEW PATIENT MEDICAL PROFILE

Today's Date________________________

Name (Last)________________________ (First)___________________(M.I.)____________

Current Complaint____

When did your Pain/Problem begin?____

Have you had similar problems before?_________________________ When?____________

Have you had Physical Therapy or Home Health Care before? _____ When?____________

If so, Where ? ____

Have you been treated for any other Health Condition in the last year?________________

If so, please indicate____

Please list all hereditary/congenital Medical Conditions______________________________

List all Surgeries/Accidents and dates____

Name ALL Medications and Dosage that you are currently taking_____________________

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Do you smoke?_______ Number of Packs per day_________________________________

Weekly Alcohol Consumption______________ Daily Water Consumption______________

Are you able to sleep through the night? ____

What activities do you wish you were able to do, but are unable because of the pain/problem that you presently have? ____

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Signature of Patient:____