



Patient Demographic Form

Full Name: _____ Birthday: __/__/__

Male Female SSN: _____ Do you need an interpreter? Y N

Address: _____

Phone Numbers: Home: _____

Mobile: _____

Preferred Appointment Reminders

Text Message

Voice Call

Text Message

Voice Call

Email

Email Address: _____

Marital Status: Married Single Unknown

Student Status: Full-time Part-time None

Employment Status: Full-time Part-Time Self-Employed Retired None

Employer Information

Name of Employer: _____

Work Phone: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Whom may we thank for your referral? Name: _____

Physician

Hospital

Event

Employer

Attorney

Friend

Case Manager

Marketing Ad - Print

Former Patient

Adjustor

Marketing Ad - Facebook

Self – Returning patient

Signature Date: _____

Medical History

Patient Name: _____ Date: _____

Previous Surgeries		
Type of Surgery	Date of Surgery	Details
Diagnostic Testing		
Test Performed	Date of Test	Details
ABR/BAER (Brainstem Testing)		
Bloodwork/Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study/Empty Scan		
MRI		
NCV (Nerve Conduction Testing)		
Swallow Study		
Upper Endoscopy		
Xray		
Other:		
Specialists		
Type	Name	Reason
Allergist		
Audiologist		
Cardiologist		
Developmental Medicine		
Endocrinologist		
ENT		
Gastroenterologist		
General Surgeon		
Hand Surgeon		
Internal Medicine		
Nephrologist		
Neuro-Surgeon		
Neurologist		
OBGYN		
Oncologist		
Orthopedic Surgeon		
Pediatrician		
Physiatrist		
Podiatrist		
Psychiatrist/Psychologist		
Rheumatologist		
Thoracic Surgeon		
Urologist		

Medical Conditions:

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Lupus | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Syncope/Fainting |
| <input type="checkbox"/> Cauda Equina | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental/Cognitive Disorder | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Current Infection | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Pregnancy (Current) | <input type="checkbox"/> Weight Change |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Falls | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Prolonged Steroid Use | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Huntington's | <input type="checkbox"/> Obesity | <input type="checkbox"/> Recent Fractures | |

Other Conditions (not mentioned above): _____

Medications			<input type="checkbox"/> Attached Medication List
Medication	Dose	Reason	

Allergies		
Type	Reaction	Severity

Recent Hospitalization		
Type	Name of Facility	Discharge Date
Hospitalization		
Skilled Nursing Care (Nursing Home)		
Home Health Care		
Outpatient Therapy (Since Jan. 1st)		Number of Visits: <input type="text"/>

Social History:

- Current Smoker: Y N Packs per day: _____ Year Smoking: _____
 Previous Smoker: Y N Years smoke free: _____ Years Smoked: _____
- Alcohol: Often Occasionally Never
 Recreational Drugs: Often Occasionally Never
 Living Situation: House Apartment Stairs in Home
 Alone Family/Roommate

Current Pain Location: _____

Pain Level at its worst: 0 1 2 3 4 5 6 7 8 9 10

Current Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Pain Level at its best: 0 1 2 3 4 5 6 7 8 9 10

Pain Description: Burning Sharp Dull/Achy Throbbing Shooting Numbness/Tingling Constant

Intermittent Worse in the morning Worse in the evening Other: _____

Patient Signature

Therapist Review Signature

Date Reviewed: _____