Today's Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have X-rays / MRI taken? ◻ Yes ◻ No Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

### **General Personal History** – Please indicate whether you have ever had one of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **◻** High blood pressure | **◻** Asthma | | | **◻** Blood clots (DVT) |
| **◻** Heart failure (CHF) | **◻** Stroke (CVA) | | | **◻** Kidney failure |
| **◻** Diabetes mellitus **◻** Insulin dependent **◻** Non-insulin dependent | | | **◻** Thyroid disease | |
| **◻** Heart attack (year: \_\_\_\_\_\_) | **◻** Fractures | | **◻** Heart failure (CHF) | |
| **◻** Stomach ulcer–bleeding? **◻** Yes **◻** No |  | | |  |
| **◻** Cancer (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **◻** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

### **Family History**: Please indicate if any direct relative has had one of the following

|  |  |
| --- | --- |
| Disease/Condition/Disorder | Please Explain |
| Diabetes mellitus |  |
| Rheumatoid arthritis |  |
| Hypertension |  |
| Heart disease/disorder |  |
| Cancer |  |
| Other |  |

### **Review of Systems**: Please check all that apply to you

|  |  |  |  |
| --- | --- | --- | --- |
| General | **◻** Fatigue | **◻** Unexplained weight change | **◻** Fever |
| Skin | **◻** Jaundiced | **◻** Bruising | **◻** Rash / ulcers |
| Musculoskeletal | **◻** Stiffness  **◻** Weakness | **◻** Joint pain  **◻** Fibromyalgia | **◻** Swelling  **◻** Myofascial Pain |
| Respiratory | **◻** Tuberculosis | **◻** Shortness of breath | **◻** Chronic cough |
| Cardiovascular | **◻** Blood clots | **◻** Chest pain | **◻** Palpitations |
| Gastrointestinal | **◻** Blood in stool  **◻** Change in bowel habits | **◻** Heartburn / ulcers **◻** Nausea / vomiting | **◻** Stomachache caused by anti-  inflammatory medications |
| Neurological | **◻** Tingling  **◻** Numbness | **◻** Headaches  **◻** Seizures | **◻** Sensory deficit |
| Psychiatric | **◻** Anxiety / nervousness | **◻** Depression | **◻** Insomnia |
| Endocrine | **◻** Heat / cold intolerance |  | |
| Hematology | **◻** Blood disorders | **◻** Anemia | **◻** Easy bruising / bleeding |

### **Medication Information**: List your current medications and dosage. Include prescription and non-prescription items.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Surgical History**: List any surgeries and related information below

|  |  |  |
| --- | --- | --- |
| Type of Surgery | Date of Surgery | Surgeon / Hospital |
|  |  |  |
|  |  |  |
|  |  |  |

**Social History:**

|  |
| --- |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you use tobacco products? **◻** Yes or **◻** No If yes, packs per day \_\_\_\_\_\_\_\_ |
| Do you drink alcohol? **◻** Yes or **◻** No If yes, drinks per week \_\_\_\_\_\_\_\_ |
| Are you currently pregnant? **◻** Yes or **◻** No |

### **Emergency Contact Information**:

### Primary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement and Consent to Treat:**

I, the undersigned, attest that the information on this form is accurate to the best of my knowledge. I also give my informed consent to Erbst OrthoSport Physical Therapy, LLC to provide me with the appropriate examination and treatment for my condition.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation/No-Show Policy:**

I, the undersigned, am aware that Erbst OrthoSport Physical Therapy, LLC requires 24 hour notice for all cancellations.

I understand that a cancellation with less than 24 hour notice or a “no show” may result in a full visit charge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_