Submit by Email | Print Form

Patient Information

Eval Date & Time:_____

Patient Name: _____ Date: _____

Address: _____City/State_____ Zip _____

DOB: _____ SSN: _____ Sex: M F

Daytime Phone #: _____ Evening Phone #:_____ Cell#:_____

Do you receive TEXT messages on your cell phone? ☐ Yes ☐ No

Email Address: _____Language:_____ Marital Status: _____

Emergency Contact: _____ Relationship: _____ Phone #:_____

Referring Doctor:_____ Date of next appointment to see this doctor?_____

Primary Physician (if different):_____ Phone #:_____

Are you seeing any specialists for this condition other than listed above? If so, please list below:

Name: _____Phone#:_____

Diagnosis: _____ Date of Rx: _____

Who has Rx? ☐ Patient ☐ Doctor ☐ Reavis Date of Injury/Surgery: _____

Problem: ☐ Non-Injury ☐ Injury/Accident ☐ Post-Surgery (Non-Injury) ☐ Post Surgery (Injury)

If Injury or Accident: ☐ Work Injury ☐ Motor Vehicle Accident ☐ Sport Injury ☐ Other

Details of Injury/Accident: _____

Services Requested: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Acupuncture ☐ Nutrition

Are you receiving Home Health Services? ☐ Yes ☐ No D/C date: _____

Name of Home Health Agency: _____Phone: _____

Referral Source: _____ (How Did you hear about us?)

Functional Limitations:

- ☐ Amputation
- ☐ Blind
- ☐ Hearing
- ☐ Incontinence
- ☐ Walking

Do your daily activities involve the following?

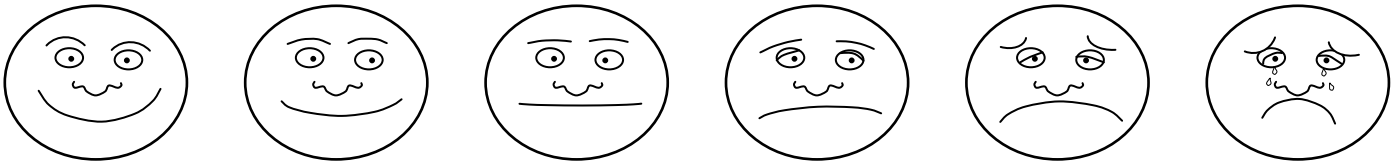
- ☐ Carrying
- ☐ Prolonged Sitting (Greater than 30 minutes)
- ☐ Prolonged Standing (Greater than 30 minutes)
- ☐ Lifting: Average Weight: _____ lbs.
- ☐ Other:_____

What tests have you had for this Condition?

- ☐ X-Ray
- ☐ CT Scan
- ☐ MRI
- ☐ EMG/NCV
- ☐ Arthrogram
- ☐ Bone Scan
- ☐ Blood Test
- ☐ Other: _____
- ☐ Arthroscopy
- ☐ Other: _____

Medical History	**Yes**	**No**
Have you been hospitalized for this condition? If so, write in other information below.	☐	☐
Have you had prior problems with current involved body area? If so, write in other information below.	☐	☐
Have you been treated by other health care providers (i.e. Chiropractor) for this diagnosis?	☐	☐

How would you rate your level of pain today?



No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst
☐	☐	☐	☐	☐	☐

Please fill out all four sections below	**Yes**	**No**
Have you had **physical therapy** services for current condition? If so, write in other information below.	☐	☐
Do you experience pain in your trunk, hips, legs and/or feet?	☐	☐
Do you have difficulty with mobility for tasks such as work duties, housework, etc.?	☐	☐
Do you experience frequent falls or balance problems?	☐	☐
Do you have trouble performing tasks such as walking, driving, etc.?	☐	☐

Have you had **occupational therapy** for current condition? If so, write in other information below.	☐	☐
Do you experience pain in your shoulders, arms, wrists, and/or hands?	☐	☐
Do you need assistance to dress yourself?	☐	☐
Do you need assistance to fasten closures on clothes (buttons, snaps, etc.)?	☐	☐
Do you have trouble manipulating small objects?	☐	☐
Do you require assistance to prepare a meal?	☐	☐
Do you need assistance to care for children (lifting, etc.)?	☐	☐
Do you need assistance to clean your home?	☐	☐
Do you have difficulty engaging in your favorite hobbies?	☐	☐
Do you have difficulty performing on the job tasks?	☐	☐

Have you had **speech therapy** services for current condition? If so, write in other information below.	☐	☐
Do you have a difficult time expressing yourself?	☐	☐
Do other individuals have difficulty understanding what you say?	☐	☐
Do you exhibit slurred speech?	☐	☐
Do you have difficulty identifying objects?	☐	☐
Do you have difficulty finding the correct word to say?	☐	☐
Do you have difficulty remembering events, people, or activities?	☐	☐
Do you have difficulty swallowing water or other liquids?	☐	☐
Do you have difficulty swallowing different textured foods?	☐	☐
Do you have trouble making decisions?	☐	☐

Do you require assistance with transportation?	☐	☐
Do you need assistance with shopping/errands?	☐	☐
Do you need assistance with meals/personal care?	☐	☐
Do you need assistance with job placement or retraining?	☐	☐
Have you lost interest in things you used to enjoy?	☐	☐
Have you been feeling sad or down in the dumps?	☐	☐
Does the future look bleak and hopeless?	☐	☐
Have you noticed a change in your eating or sleeping habits?	☐	☐
Has your current injury or illness caused problems you have trouble dealing with?	☐	☐

For Office use only: Referral made to: PT_____ OT_____ ST_____
(Initial and date)

Health History
Confidential

Current	Past	Check (✓) symptoms you currently have or have had in the past.
☐	☐	AIDS
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis/Osteoarthritis
☐	☐	Bleeding Disorders
☐	☐	Cancer
☐	☐	Chest Pain
☐	☐	Complex Region Pain Syndrome
☐	☐	Convulsions/Seizures
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Dizziness
☐	☐	DVT / Blood Clots
☐	☐	Emphysema / COPD
☐	☐	Epilepsy
☐	☐	Fainting
☐	☐	Fibromyalgia
☐	☐	Gout
☐	☐	Hardware/Implants
☐	☐	Head Injury
☐	☐	Headaches/Migraines
☐	☐	Hearing Problems
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heartbeat Irregular

Current	Past	Check (✓) symptoms you currently have or have had in the past.
☐	☐	Hepatitis
☐	☐	Hernia
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	HIV Positive
☐	☐	Indwelling Circuitry/Pacemaker
☐	☐	Infection
☐	☐	Kidney Disease
☐	☐	Lupus
☐	☐	Multiple Sclerosis
☐	☐	Osteoporosis
☐	☐	Phlebitis
☐	☐	Pregnant
☐	☐	Psychological Disorder
☐	☐	Rheumatic Fever
☐	☐	Shortness of Breath
☐	☐	Smoking / Alcohol / Drugs
☐	☐	Stroke
☐	☐	Swollen Ankles
☐	☐	Throat Problems
☐	☐	Thyroid Disease
☐	☐	Tuberculosis
☐	☐	Urinary Problems
☐	☐	Visual Problems

MEDICATIONS List all medications or supplements you are currently taking

Name	Dose	Frequency

Therapist Signature:_____ Date Reviewed: _____

Patient Name: _____

Insurance Information

Have you had PT, OT, ST or Chiropractic for this injury/illness? If yes, enter number of visits and which type?

PT_____ OT_____ ST_____ Chiro_____ Date Discharged? _____

Name of Hospital Out-patient:_____ Clinic Name:_____

Primary Insurance: _____Phone#:_____

Insured Name: _____ Relation to Patient: _____

Insured Soc.Sec.No: _____ Insured Date of Birth: _____

Employer Name: _____ Phone: _____

Policy / Member / ID #:_____ Group #:_____

Check: ☐ HMO ☐ PPO ☐ POS ☐ Medicare A ☐ B Plan Name:_____

Secondary Insurance: _____Phone#:_____

Insured Name: _____ Relation to Patient: _____

Insured Soc.Sec.No: _____ Insured Date of Birth: _____

Employer Name: _____ Phone: _____

Policy / Member / ID #:_____ Group #:_____

Check: ☐ HMO ☐ PPO ☐ POS ☐ Medicare A ☐ B Plan Name: _____

Tertiary Insurance: If yes, list below.

Worker's Comp (WC) or Motor Vehicle Accident (MVA): DATE OF INJURY: _____

For **MVA:** ☐ Attorney ☐ Claim filed ☐ Claim open ☐ Third party Ins.

Attorney Name: _____ Phone: _____

For **WC**: Employer: (on date of injury):_____ Phone: _____

Employer Contact Name: _____ Phone: _____

Insurance Company Name: _____ Insurance Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____ Claim Adjuster or Case Mgr.: _____

Phone: _____ Ext: _____ Fax: _____

Other information that could impact your care:

Date and approximate time you would like for evaluation: