

ILLNESS INJURY Date of Injury/Onset of Symptoms: _____
 What body part is involved: _____ Left Right
 Injury Occurred: Home Employment* School* Recreation* Pedestrian* MVA/Auto*
 Other – Briefly explain: _____

***If this is a Workers Comp/Liability/Auto Claim - Please Complete Section Below**

Name of Workers Compensation/Liability/Auto Insurance: _____
 State that incident occurred in: _____ Claim #: _____
 Insurance Adjusters Name: _____
 Phone Number: _____ Extension Number: _____
 Has an Attorney been obtained: Yes No – If yes please complete below
 Attorney Name: _____ Phone: _____

ADDITIONAL INFORMATION: (required)

Employer: _____ Phone: _____ Retired
 Address: _____ Job Description: _____
 Are you a student? Yes No Full Time Part Time

MEDICAL HISTORY

Please check any medical conditions that we should be aware of:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scoliosis/Back Disorder	<input type="checkbox"/> Heart Attack/Heart Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung Disorders	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Cancer	<input type="checkbox"/> Ulcer/Digestive	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Vertigo

Are you Pregnant? yes no

Any Other Conditions/Concerns that we should be aware of?: _____

Surgeries and Surgical Dates: _____

Medication List Attached: Please complete

ALLERGIES: _____

Have you had any diagnostic testing performed related to your current injury?

MRI X-ray CT Scan EMG None Other: _____

To the best of my knowledge, the information that I have given is complete and true.

Patient/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____