Patient Contact Information

Today's Date_____

Patient Name_____
DOB_____
Address_____
City_____ State_____ ZipCode_____
Gender_____ Marital Status_____
Occupation_____
Home Phone_____ Cell Phone _____
Which number to do prefer to be contact at:

☐ Home ☐ Cell
☐ Work

Email_____
Employer_____
Work Phone _____
Work Address_____
City_____ State_____ ZipCode_____

Parent/Guardian/Spouse/Partner (Must complete if patient is under 18 years.)

Name_____
Address_____
City_____ State_____ ZipCode_____
Home Phone_____ Cell Phone _____

Emergency Information/ Nearest Relative

☐ **Same as above**

Name_____Relationship_____
Address_____ City_____ State_____
Zip Code_____
Home Phone_____ Cell Phone _____
Work Phone _____

☐ Medical information can be shared with this person.

Physician Information

Name_____
Address_____ City_____ State_____
Zip Code_____
Phone Number_____

I/We authorize *Bluegrass Doctors of Physical Therapy, PLLC* to release all medical information and/or records to my requesting insurance company and/or Referring physician (if referred from a physician)

_____ _____
Patient Signature Date

Patient Questionnaire Date_____

Name_____

From whom did you hear about us?_____

History of current condition: (Please describe location, intensity, duration, and onset of condition. Use back of form if needed)

_____

_____

_____

Any special tests that have been performed, the body part tested, and the results: (ie: X-ray, MRI, Cat Scan)_____

_____

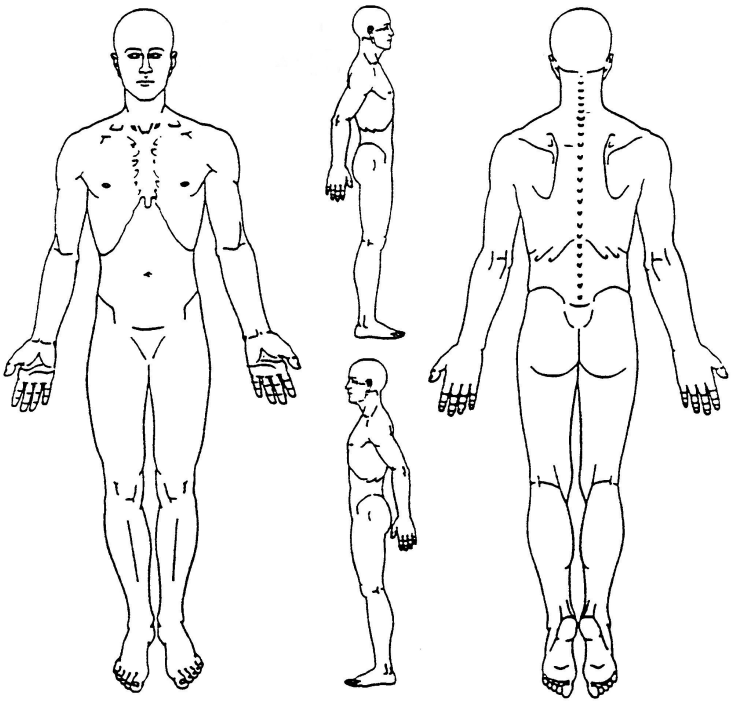
Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

_____

_____

_____

Please indicate the areas you are having pain.
You may shade, color or simply mark the areas.



Please rate the intensity of your pain at its worse below:
0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain worse?

_____

_____

_____

_____

Please rate the intensity of your pain at its best below:
0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain better?

_____

_____

_____

_____

Have you been advised to have any surgery that has not been done? When and what?

_____

_____

Please list all previous injuries, accidents, surgeries and any other pertinent medical information. (Please include dates and type of surgery.)

_____

_____

_____

Please list *all* medical conditions and/or health concerns

_____

_____

_____

Please list *all* current medications:

_____

_____

Please list all allergies including any latex, gels creams, adhesives or nickel allergies:

_____

_____

Do you currently have any metal, plastics or implants anywhere in your body?

_____

_____

Do you now have or have you had any of these symptoms in the past year? (Check all that apply)

- ☐ Change in bowel movements
- ☐ Persistent joint pain
- ☐ Irritable bowel
- ☐ Blood in bowel/urine
- ☐ Hot flashes
- ☐ Vertigo or dizziness
- ☐ Persistent nose bleeds
- ☐ Difficulty concentrating
- ☐ Learning disabilities
- ☐ Tiredness/fatigue
- ☐ Muscle spasms
- ☐ Fainting spells
- ☐ Eating disorder/difficulty
- ☐ Difficulty Sleeping
- ☐ Seizures/Epilepsy
- ☐ Osteoporosis/Osteopenia
- ☐ Other_____

_____

_____

Any history of: (check all that apply)

- ☐ None
- ☐ Kidney Problems
- ☐ Dislocations or loose joints
- ☐ Head or spinal injuries
- ☐ Recurrent headaches:
- ☐ How often _____
- ☐ Knocked unconscious:_____
- ☐ Meningitis
- ☐ Stomach ulcers
- ☐ Heartburn/indigestion
- ☐ Shortness of breath
- ☐ Anemia
- ☐ Asthma
- ☐ Bladder infection
- ☐ High Cholesterol
- ☐ Heart Problems
- ☐ Depression
- ☐ Smoking/Tobacco products: How much?_____
- ☐ Cancer? If so what kind?_____
- ☐ Other_____

Dental History: (Only for patients with headaches and TMJ)

Who is your dentist?_____

Please check all that apply:

- ☐ Braces:_____
- ☐ Retainer: _____
- ☐ Grind or clench teeth
- ☐ Night Guard
- ☐ TMJ Disorder
- ☐ Popping or clicking in jaw
- ☐ Jaw locked
- ☐ Other:_____

FOR WOMEN ONLY:

Please check if you have had a history of:

- ☐ Interstitial cystitis
- ☐ Pelvic inflammatory disease
- ☐ Endometriosis
- ☐ Pelvic pain
- ☐ Pregnancy: number of: _____ pregnancies _____children
- ☐ Currently pregnant: Current term_____
- ☐ Take birth control? How long?_____
- ☐ Cramping
- ☐ Irregular menstrual cycle

Any other information about pregnancies, complications with delivery, menstrual problems?

_____

_____

_____

_____ _____

Patient Signature Date

Please let your Bluegrass Doctor of Physical Therapy know if there is any other information that you feel is important for us to know.