North Orange County Physical Rehabilitation

NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:______________________________

Name Last)______________________________________ (First)_____________________________________((M.I.) ______

Birth Date________________________ Social Security____________________________________ Age _____Sex: M / F

Home Address____

City____ State__________ Zip____________________________

Complaint/ Area to be treated______________________________ Email Address_____________________________________

Home Phone (_____)________________ Drivers Lic #________________________Work Phone (_____)________________

Injury Date ____________________ Other Phone (______)________________ Date First Consulted__________________

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Employment Full / Part-time / Not Working / Retired **Employer**____

Emergency Contact______________________________________Relation__________________ Phone__________________

Referring Physician____ Telephone _______________________________

Who may we thank for your referral other than your Doctor?____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other________________________Lawyer Involved Yes/ No

Attorney name ____

Address____ Telephone # (______)________________

Patient Signature:____**Date:**____________________

(OFFICE USE ONLY)

02/28/06

Primary Insurance____

Insured Name____Social Sec#____________________________D.O.B.__________

Relation to Patient Spouse / Child / Other

Secondary Insurance____

Insured Name____Social Sec#____________________________D.O.B.__________

Relation to Patient Spouse / Child / Other

Referring Dr. Address ____ UPIN # __________________________

Area(s) Being Treated:____

Diagnosis Code _____________________ Description: ____

Financial Class: CASH COMMERCIAL INSURANCE MC LIEN W/C HMO

Provider:

INITIAL HEALTH STATUS
PTOT

Patient Name_________________________ Subscriber ID #_________________ Primary Language________

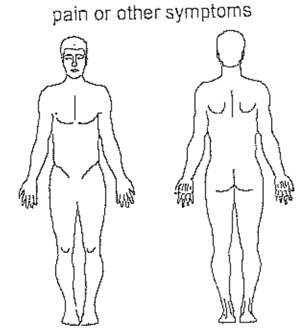
Describe Your Current Problem and How It Began____

____

____

Onset date/Surgery date____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?
☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:
☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?
☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_________________________ What areas were taken?_________________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date)_________________________
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain)_________________________
____
☐ Osteoporosis
☐ Other Health Problems (Explain)_________________________
____

☐ Numbness (Location)_________________________
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_________________________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries_________________________
____
☐ Tobacco Use - Type_________________________
Frequency_________________________/Day
☐ Current Medications_________________________
____

Who have you seen for your condition before today?
☐ No One ☐ Medical Doctor ☐ Massage Therapist ☐ Other_________________________
☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist

What treatment did you receive and when?____

What is your occupation?____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient Signature____ Date_________________