Jason Marvin PT

Manual Physical Therapist

New Patient Information & Medical History Form

Patient Name: _____ **Date of Birth:** _____
(Last) (First) (MI)

If a minor, name of parent or legal guardian: _____

Home Address: _____
(Number & Street)

_____
(City) (State) (Zip Code)

Mailing Address (if different):_____
(Number & Street)

_____
(City) (State) (Zip Code)

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **E-mail Address:** _____

Employer: _____
(Employer Name) (Employer Address)

Spouse's Name: _____ **Spouse's Employer:** _____

Spouse's Work Phone: _____ **Spouse's Cell Phone:** _____

Person to notify in case of emergency (must be someone NOT living in same household):

Name: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Referred by: _____

What is the reason for your visit? _____

_____

(Confidential)

Patient Name: _____ **Today's Date:** _____

Age: _____ **Date of Birth:** _____ **Date of last physical examination:** _____

Symptoms

Check (✔) symptoms you currently have or have had in the past year.

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

MUSCLE / JOINT / BONE
Pain, weakness, numbness in:
- ❑ Arms ❑ Hips
- ❑ Back ❑ Legs
- ❑ Feet ❑ Neck
- ❑ Hands ❑ Shoulders

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL
- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sin us problems
- ❑ Vision - Flashes
- ❑ Vision -Halos

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

MEN Only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN Only
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

Conditions

Check (✔) symptoms you currently have or have had in the past year.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name_____ Phone _____

Allergies

_____

_____

_____

_____

_____

Health History

(Confidential)

Patient Name: _____ **Today's Date:** _____

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if your blood relatives had any of the following: Disease	Relationship to you.
Father					Arthritis	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, please give approximate dates _____

Serious Illness / Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✔) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✔) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

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(Confidential)

Patient Name: _____ **Today's Date:** _____

Do you have any surgical or traumatic scars? _____

_____

Please list any injuries such as sprains/strains to muscles and joints, falls or fractures: _____

_____

Tell me about the extent of dental work you've had (i.e. orthodontia, cavities, TMJ correction, caps and root canals): _____

_____

Tell me about your diet: _____

_____

Do you have an exercise program? _____ **If yes, describe it for me:** _____

_____

_____

What do you do for stress management? _____

_____

Is there anything else you would like me to know about your physical or emotional health? _____

_____

_____

Is there anything else you would like to tell me about your health? _____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my Physical Therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

Signature of legal guardian (If patient is a minor): _____ **Date:** _____

Reviewed by: _____ **Date:** _____

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