WPT New Patient Information

Patient Name:	Phone #:		
Address:	City/St	ate/Zip:	
DOB:Age:	Social Secur	ity #:	
Email Address			-
Marital Status:Spo	use's Name:	Phone:	
Employer:	Occupation:		
Emergency Contact:		Phone:	
Referring Physican:	Prim	nary Care Physician:	
Is there anyone we can dis Name:		formation with? YES	S NO
How may we contact you i	regarding appointme	ents? TEXT EMAIL	
Have you been a patient b Year:Reason:			
How did you hear about us Internet Paper Frien			
I hereby authorize WPT, the and treatment to me or the broper in diagnosing or tre	e above named patie eating my physical co	ent, considered necesso	
Acknowledgement of recei Name:		cy practices. Date:	

MEDICAL HISTORY – Please circle YES or NO		r NO	Chief Complaint			
ALLERGIES	YES	NO	Body Part			
ANEMIA	YES	NO				
ANXIETY	YES	NO	Have you had an injury as a result of a fall in the			
ARTHRITIS	YES	NO	past year? YES NO			
ASTHMA	YES	NO				
AUTOIMMUNE DISORDER	YES	NO	Two or more falls in the last year?			
CANCER	7ES	NO	YES NO			
CARDIAC CONDITIONS	YES	NO				
CARDIAC PACEMAKER	YES	NO	Body Height:Body Weight:			
CHEMICAL DEPENDENCY	YES	NO				
CLIRCULATION PROPBLEMS	YES	NO	Current Medications:			
CURRENTLY PREGNANT	YES	NO				
DEPRESSION	YES	NO				
DIABETES	YES	NO				
DIZZY SPELLS	YES	NO	Allergies:			
EMPHYSEMA	YES	NO				
FIBROMYALGIA	YES	NO	History of Present Injury:			
FRACTURES	YES	NO				
GALLBLADDER PROBLEMS	YES	NO				
HEADACHES	YES	NO	Severity: (0=no pain 10=worst pain)			
HEARING IMPAIRMENT	YES	NO				
HEPATITIS	YES	NO	When:			
HIGH CHOLESTEROL	YES	NO	Sudden Constant Comes and Goes Sleep			
BLOOD PRESSURE	YES	NO	With Movement Only			
HIV/AIDS	YES	NO				
INCONTINENCE	YES	NO	What else do you experience:			
KIDNEY PROBLEMS	YES	NO				
METAL IMPLANTS	YES	NO	Swelling Sleeping Problems			
MRSA	YES	NO				
MULTIPLE SCLEROSIS	YES	NO	Have you previously seen someone for this			
MUSCULAR DISEASE	YES	NO	current problem?			
OSTEOPEROSIS	YES	NO	MD Chiropractor PT/OT			
PARKINSON'S	YES	NO				
RHEUMATOID ARTHRITIS	YES	NO	Have you had any of the following:			
SEIZURES	YES	NO	X-ray Bone Scan MRI CT Scan			
SMOKING	YES	NO				
SPEECH	YES	NO	Where:			
STROKES	YES	NO	When:			
THYROID	YES	NO				
TUBERCULOSIS	YES	NO				
VISION	YES	NO				

Name	Date of Birth	Today	y's Date	
1 (MIII)	Dute of Birth	- 0 444	, , , , , , , , , , , , , , , , , , , ,	

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty with the activities listed below because of your upper limb problem for which you are currently seeking attention. Provide an answer for each activity.

Today, do you or would you have any difficulty with: (Circle one number on each line)

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities.	0	1	2	3	4
 b. Your usual hobbies, recreational or sporting activities. 	0	1	2	3	4
c. Lifting a bag of groceries to waist level.	0	1	2	3	4
d. Lifting a bag of groceries above your head.	0	1	2	3	4
e. Grooming your hair.	0	1	2	3	4
f. Pushing up on your hands (e.g., from bathtub or chair).	0	1	2	3	4
g. Preparing food (e.g., peeling, cutting).	0	1	2	3	4
h. Driving.	0	1	2	3	4
i. Vacuuming, sweeping, or raking.	0	1	2	3	4
j. Dressing.	0	1	2	3	4
k. Doing up buttons.	0	1	2	3	4
I. Using tools or appliances.	0	1	2	3	4
m. Opening doors.	0	1	2	3	4
n. Cleaning.	0	1	2	3	4
o. Tying or lacing shoes.	0	1	2	3	4
p. Sleeping.	0	1	2	3	4
 q. Laundering clothes (e.g., washing, ironing, folding). 	0	1	2	3	4
r. Opening a jar.	0	1	2	3	4
s. Throwing a ball.	0	1	2	3	4
t. Carrying a small suitcase with your affected limb).	0	1	2	3	4
COLUMN TOTALS (for physical therapist use)					

Score is the sum of all circled items. (range = 0-80)

Score: ____/80