WPT New Patient Information

Patient Name:____________________________ Phone #:__________________________

Address:______________________________ City/State/Zip:_________________________

DOB:____________ Age:___________ Social Security #:___________________________

Email Address____

Employer:__________________________________ Phone:______________________

Spouse's Name:____________________ Number:______________________

Emergency Contact:_________________________ Phone:_______________________

Referring Physican:______________________ Primary Care Physician:_______________

Is there anyone we can discuss your medical information with? YES NO
Name:_________________________________

How may we contact you regarding appointments? TEXT EMAIL

Have you been a patient before? YES NO
Year:_________ Reason:_____________

How did you hear about us?
Internet Paper Friend/Family....Name______________

I hereby authorize WPT, through its appropriate personnel to furnish medical care and treatment to me or the above named patient, considered necessary and proper in diagnosing or treating my physical condition.
*Signature:*__________________________________ *Date:*_____________________

Acknowledgement of receipt of Notice of Privacy practices.
*Name:*______________________________________ *Date:*______________________

MEDICAL HISTORY---Please circle YES or NO

ALLERGIES	YES	NO
ANEMIA	YES	NO
ANXIETY	YES	NO
ARTHRITIS	YES	NO
ASTHMA	YES	NO
AUTOIMMUNE DISORDER	YES	NO
CANCER	YES	NO
CARDIAC CONDITIONS	YES	NO
CARDIAC PACEMAKER	YES	NO
CHEMICAL DEPENDENCY	YES	NO
CIRCULATION PROBLEMS	YES	NO
CURRENTLY PREGNANT	YES	NO
DEPRESSION	YES	NO
DIABETES	YES	NO
DIZZY SPELLS	YES	NO
EMPHYSEMA	YES	NO
FIBROMYALGIA	YES	NO
FRACTURES	YES	NO
GALLBLADDER PROBLEMS	YES	NO
HEADACHES	YES	NO
HEARING IMPAIRMENT	YES	NO
HEPATITIS	YES	NO
HIGH CHOLESTEROL	YES	NO
BLOOD PRESSURE	YES	NO
HIV/AIDS	YES	NO
INCONTINENCE	YES	NO
KIDNEY PROBLEMS	YES	NO
METAL IMPLANTS	YES	NO
MRSA	YES	NO
MULTIPLE SCLEROSIS	YES	NO
MUSCULAR DISEASE	YES	NO
OSTEOPEROSIS	YES	NO
PARKINSONS	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
SEIZURES	YES	NO
SMOKING	YES	NO
SPEECH	YES	NO
STROKES	YES	NO
THYROID	YES	NO
TUBERCULOSIS	YES	NO
VISION	YES	NO

PLEASE COMPLETE IN FULL

Body Part: ______________________________

☐ Left ☐ Right ☐ Both

Chief Complaint: (Please check all that apply)

☐ Pain ☐ Stiffness ☐ Weakness

☐ Loss of Balance ☐ Loss of function

☐ Other:______________________________

Have you had an injury as a result of a fall in the past year? Yes NO

Two or more falls in the last year?

YES NO

Have your symptoms been present?

☐ Less than 2 months ☐ 2-3 Months

☐ More than 3 months

Body Height:__________ **Body Weight:**__________

Current Medications:______________________________

____

____

Allergies:______________________________

History of Present Injury:

Severity: (0=no pain 10=worst pain) ______

When:

☐ Sudden ☐ Comes and Goes ☐ Constant

☐ With Movement Only ☐ During Sleep

☐ Other:______________________________

What else do you experience:

☐ Swelling ☐ Problems Sleeping

Have you previously seen someone for this current problem?

MD Chiropractor PT/OT

Have you had any of the following:

X-ray Bone Scan MRI CT Scan

Where:______________________________

When:______________________________

Lower Extremity Functional Scale

Final Score ____/ 80

Name ________________ Visit ________________ Date ________________

Please rate the severity of your pain over the last week by circling a number below

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

Please circle one response to each question.

	Extreme difficulty or unable to perform	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (≈ 1 flight)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4
Sum Column Totals:					