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: _____

Neck Disability Index

Sum of Scores _____ x 2 = _____ Final Score

Name Date Visit

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 10 Unbearable pain

Please circle the ONE NUMBER in each section which most closely describes your problem.

Section 1 - Pain Intensity

0 I have no pain at the moment.
1 The pain is very mild at the moment.
2 The pain is moderate at the moment.
3 The pain is fairly severe at the moment.
4 The pain is very severe at the moment.
5 The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc.)

0 I can look after myself normally, without causing extra pain.
1 I can look after myself normally, but it causes extra pain.
2 It is painful to look after myself and I am slow and careful.
3 I need some help, but manage most of my personal care
4 I need help every day in most aspects of self care.
5 I do not get dressed; I wash with difficulty and stay in bed.

Section 3 - Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights, but it gives extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4 I can lift very light weights.
5 I cannot lift or carry anything at all.

Section 4- Reading

0 I can read as much as I want to, with no pain in my neck.
1 I can read as much as I want to, with slight pain in my neck.
2 I can read as much as I want to, with moderate pain in my neck.
3 I can't read as much as I want, because of moderate pain in my neck.
4 I can hardly read at all, because of severe pain in my neck.
5 I cannot read at all.

Section 5 - Headaches

0 I have no headaches at all.
1 I have slight headaches that come infrequently.
2 I have moderate headaches that come infrequently.
3 I have moderate headaches that come frequently.
4 I have severe headaches that come frequently.
5 I have headaches almost all the time.

Section 6 - Concentration

0 I can concentrate fully when I want to, with no difficulty.
1 I can concentrate fully when I want to, with slight difficulty.
2 I have a fair degree of difficulty in concentrating when I want to.
3 I have a lot of difficulty in concentrating when I want to.
4 I have a great deal of difficulty in concentrating when I want to.
5 I cannot concentrate at all.

Section 7 - Work

0 I can do as much work as I want to.
1 I can do my usual work, but no more.
2 I can do most of my usual work, but no more
3 I cannot do my usual work.
4 I can hardly do any work at all.
5 I can't do any work at all.

Section 8 - Driving

0 I can drive my car without any neck pain.
1 I can drive my car as long as I want, with slight pain in my neck.
2 I can drive my car as long as I want, with moderate pain in my neck.
3 I can't drive my car as long as I want, because of moderate pain in my neck.
4 I can hardly drive at all, because of severe pain in my neck.
5 I can't drive my car at all.

Section 9 - Sleeping

0 I have no trouble sleeping.
1 My sleep is slightly disturbed (less than 1 hour sleepless).
2 My sleep is mildly disturbed (1-2 hours sleepless).
3 My sleep is moderately disturbed (2-3 hours sleepless).
4 My sleep is greatly disturbed (3-5 hours sleepless).
5 My sleep is completely disturbed (5-7 hours sleepless).

Section 10 - Recreation

0 I am able to engage in all my recreation activities, with no neck pain at all.
1 I am able to engage in all my recreation activities, with some neck pain.
2 I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
3 I am able to engage in a few of my recreation activities, because of pain in my neck.
4 I can hardly do any recreation activities, because of pain in my neck.
5 I can't do any recreation activities at all.