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: _____

Name _____ Date of Birth _____ Today's Date_____

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
a. 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
l. 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