SMOKY MOUNTAIN
SPORTS MEDICINE & PHYSICAL THERAPY

# NEW PATIENT INFORMATION FORM

**(Print name AS APPEARS ON insurance card)**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient's First name: | MI: | Last Name: | Date of Birth: / / |
| Social Security # | ❑ Male ❑ Female | | Patient Nickname: |
| Mailing/Billing address: | | | |
| City: | State: | Zip Code: | Primary Contact Number: ( ) |
| Occupation: | Employer name and address: | | Employer phone no.: ( ) |
| Email Address: | | | Reminder Preference: ❑ Email ❑ Text ❑ Call |

## EMERGENCY CONTACT INFORMATION

Patient Emergency Contact: _____

Relationship to Patient: _____

Contact Phone #: _____

## ACCIDENT DETAIL INFORMATION

**PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY**

Employment related: ❑ Yes ❑ No

Accident related: ❑ Auto ❑ Yes ❑ No

Date of first symptom or accident: / /

Give details of accident:

## REFERRAL INFORMATION

*Referred to clinic by* (please check one box):

❑ Dr._____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

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Name: _____ Age: _____ DOB: _____

Primary Care Physician/Family Physician: _____

Leisure activities, including exercise routines: _____

Occupation: _____ Are you on a work restriction from your doctor? **YES** **NO**

Do you smoke? **YES** **NO** Are you latex sensitive? **YES** **NO**

Do you have a pacemaker? **YES** **NO** Please list any known allergies _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES** **NO**

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Have you RECENTLY noted any of the following (check all that apply)?

| | | |
|---|---|---|
| fatigue | muscle weakness | shortness of breath |
| fever/chills/sweats | dizziness/lightheadedness | fainting |
| nausea/vomiting | heartburn/indigestion | cough |
| weight loss/gain | diarrhea | headaches |
| falls | constipation | currently feeling down |
| difficulty maintaining balance | changes in bowel/bladder function | or hopeless |
| numbness or tingling | difficulty swallowing | |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

| | | |
|---|---|---|
| Cancer | Lung problems | Osteoporosis |
| Heart problems | Tuberculosis | Fractures |
| Chest pain/angina | Asthma | Multiple sclerosis |
| High blood pressure | Rheumatoid arthritis | Epilepsy |
| Circulation problems | Other arthritic condition | Kidney problems |
| Blood clots | Bladder/urinary tract infection | Ulcers |
| Stroke | Sexually transmitted disease/HIV | Liver problems |
| Anemia | Incontinence | Hepatitis |
| Chemical dependency | Thyroid problems | Other: _____ |
| Depression | Diabetes | |

Please list prior surgeries and date(s) _____

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Date of injury/onset of current symptoms _____ Date of surgery_____

What do you think caused your symptoms?_____

Please circle any of the following services that you are receiving currently or have had this year calendar:

Physical Therapy Occupational Therapy Chiropractic Care Massage Therapy Speech Therapy

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan Other: _____

Have you ever had this problem before? **YES** **NO** If yes, when? _____

In your current living environment: Do you have stairs? **YES** **NO**. How Many Steps to enter home _____ In Home_____

Do you live alone? **YES** **NO.** If NO with whom? _____