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**

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) _____

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? _____

Have you had any recent falls? **YES NO** If so how many _____? When did fall(s) occur? _____

How would you rate your overall quality of life? Excellent Good Fair Poor

Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

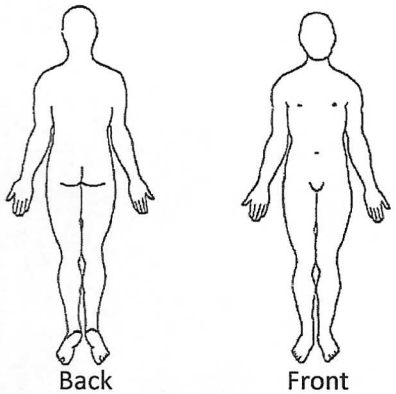
1. _____
2. _____
3. _____

Pain Assessment:

Using the scale below, please circle the **WORST** your pain has been during the **past 24 hours**.
0 = no pain, 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

On the chart to the right, please mark the areas where you feel PAIN with an "**O**" and NUMBNESS/TINGLING with an "**X**".



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Medication Assessment:
Please list any medications you are currently taking (including pills, injections, skin patches, vitamins, herbs, etc):

Medication Name	Dosage	Frequency	Route of Administration (circle how you take this med)
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch
			mouth, injection, patch