



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 #			<input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Call	

EMERGENCY CONTACT INFORMATION

Patient Emergency Contact: _____

Relationship to Patient: _____

Contact Phone #: _____

ACCIDENT DETAIL INFORMATION

PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

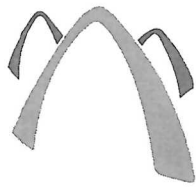
Employment related: Yes No Accident related: Auto Yes No Date of first symptom or accident: / /

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:



SMOKY MOUNTAIN
SPORTS MEDICINE & PHYSICAL THERAPY

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 or hopeless |
| difficulty maintaining balance | changes in bowel/bladder function | |
| 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? _____

