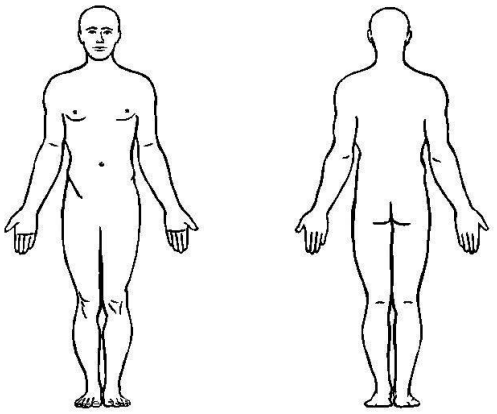
ELITECONCEPTS
PHYSICAL THERAPY
& Performance

New Patient History Form

Name:_____ Date of Birth:_____ Age:_____ Height:_____Weight:_____
Address:_____
Phone:_____Email:_____
Occupation/Sport:_____Employer:_____
Emergency Contact:_____Phone:_____
Primary Care Physician: _____Phone:_____
Specialist Physician:_____Phone:_____

How did you hear about our practice?_____

Chief Complaint / What brings you in today?
_____
_____
When did symptoms begin?_____ Cause of injury?_____
_____
Have you sought treatment for this problem? (circle) Doctor Chiropractor Massage Physical Therapy Other
Have you had any imaging? (circle) Xray MRI C-T Scan Other



Do you have PAIN related to your issue? (circle) YES NO

Where is the pain/symptom? (Indicate on diagram)

What activities/positions INCREASE your pain? (ie sitting, standing, stooping, bending)_____
_____

What activities/positions DECREASE your pain? (ie rest, sitting, lying, ice)
_____
_____

Do you have difficulty sleeping because of your pain/symptom? (circle) YES NO

Past Medical History:
Are you currently pregnant? YES NO
Do you have a pacemaker or internal stimulator (brain/spinal)? YES NO
Do you smoke? YES NO If YES, how much? _____ If NO, would you like to quit? _____

Allergies (including drugs)?_____ Allergic to Latex? YES NO

Have you had any of the following medical conditions?

Diabetes Type I Type II	YES / NO	High Blood Pressure	YES / NO
Stroke	YES / NO	Metal Implants	YES / NO
Heart Disease/Pacemaker	YES / NO	Blackouts	YES / NO
Lung Disease	YES / NO	Migraine Headaches	YES / NO
Cancer	YES / NO	Recent Weight Change (>10 lbs)	YES / NO
Neurological Problems	YES / NO	Osteoporosis	YES / NO
Epilepsy/Seizures	YES / NO	Broken Bones	YES / NO
Stroke	YES / NO	Night sweats/Excessive sweating	YES / NO
Circulatory Problems	YES / NO	Change in bowel/bladder function	YES / NO
Heart Murmur	YES / NO	Nausea/Dizziness	YES / NO
Liver/Kidney Disease	YES / NO	Arthritis	YES / NO

List past medical history and dates of occurrence. Include surgeries, accidents, and other traumas

_____
_____
_____
_____

List ALL medications which you are currently taking, the dose, and effectiveness

_____
_____
_____
_____

Additional Information:_____
_____

***Patient Goals*:**
Please list your goals or activities that you would like to be able to do as a result of physical therapy

_____
_____
_____

Name of Participant:_____

Signature of Participant/Parent/Guardian: _____Date: _____