

**Jones Physical Therapy
Patient Information**

Last Name			First Name		
Address			E-mail		
City			State		Zip
Home Ph. ()		Cell Ph. ()		Work Ph. ()	
Social Sec. No.		Sex <input type="checkbox"/> M <input type="checkbox"/> F		DOB/Age	
Driver's Lic. No.			Emergency Contact No.		
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Sep. <input type="checkbox"/> D <input type="checkbox"/> W			Employer		
Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No			Job Title		
Referring Physician			Primary Care Physician		
May we send a copy of your care plan to your Primary Care Physician?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Injury			Was this due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If your injury is due to an accident, please indicate where: <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Auto <input type="checkbox"/> Other					
Are you receiving Home Health Care at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have, or have you had any of the following conditions?

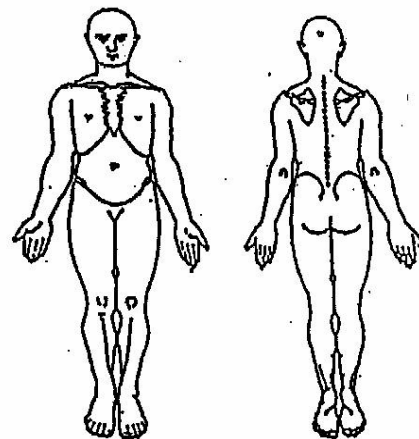
Condition	Y	N	Date	Condition	Y	N	Date
Diabetes				Bowel/Bladder Problem			
Chest Pain/Angina				Urine Leakage			
High Blood Pressure				Asthma			
Heart Disease				Emphysema			
Heart Attack				Bronchitis			
Heart Palpitations				Do you smoke?			
Mitral Valve Prolapse				Carpal Tunnel Syndrome			
Pacemaker				Head Injury			
Migraine Headaches				Claustrophobia			
Kidney Disease				Stroke			
Hernia				Hysterectomy			
Seizures				Skin Abnormalities			
HIV				Sexual Dysfunction			
Tuberculosis				Nausea/Vomiting			
Hepatitis A,B,C				Ringling in Ears			
Other Infectious Disease				Osteoporosis			
Metal Implants				Rheumatoid Arthritis			
Dizziness/Fainting				Parkinson's			
Recent Fractures				Thyroid Problems			
Recent Surgeries				Other :			

Please List All Allergies:

Please List All Medications:

Rate your pain based on a 10 point scale:
(0= No Pain 10= Highest) _____

Please mark your symptoms on the Diagram below



How did you hear about us? _____

Print Name: _____ Signature: _____

Date: ____/____/____ Guardian's Signature (if minor): _____