

Athletic Advantage, Inc.

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Patient Information

Account #	Social Security #	Title	Last Name	First Name	MI
Street Address (Road or Street)			(Apartment Number or Second Address Line)		
Zip Code	City	State	How did you learn about our practice?		
Home Phone:	Cell Phone:	Patient Data: (Nick Name)			
Birthdate	Sex (M, F)	Referring Doctor full name			
Marital <input type="checkbox"/> M-Married <input type="checkbox"/> W-Widowed <input type="checkbox"/> S-Single <input type="checkbox"/> D-Divorced <input type="checkbox"/> X-Separated	Employment <input type="checkbox"/> R-Retired <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None	Student <input type="checkbox"/> P-Part <input type="checkbox"/> F-Full <input type="checkbox"/> N-None	Relationship to Insured <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> OT-Other <input type="checkbox"/> CH-Child		
Employer Code (Office Use Only)	Employer Name				
Employer Street Address (Road or Street)					
Zip Code	City	State	Business Phone	Ext	

INSURANCE INFORMATION

Primary Insurance Company Name	Mailing Address				
Insurance Telephone #	Policy #	Group #			
Secondary Insurance Company Name	Mailing Address				
Secondary Telephone #	Policy #	Group #			

COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME

Social Security #	Title	Last Name	First Name	MI
Birthdate	Sex (M, F)	Relationship to Insured:		

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related: <input type="checkbox"/> Auto <input type="checkbox"/> Other <input type="checkbox"/> No	Date of first symptom or accident:
Give Details of Accident:		

I authorize the release of any medical or other information necessary to process insurance claims.	I authorize payment of medical benefits directly to this practice for the services rendered.
_____ Signed	_____ Signed
_____ Date	_____ Date

Athletic Advantage, Inc.
Sports Physical Therapy & Performance Development Center
New Patient Questionnaire

Name _____ Today's date _____

Diagnosis (if known) _____ Date of onset _____

Chief Complaint Today: _____

Recent Surgery? No Yes If yes, type _____ Surgery Date _____

MEDICAL HISTORY (including surgeries, injuries, diseases)

I currently have or have had a HISTORY of: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Metal implants |
| <input type="checkbox"/> Heart trouble/
Angina | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sensitive to heat/ ice |
| <input type="checkbox"/> Pace maker | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Smoker/ tobacco use | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Major injury to
neck/ back/ spine |
| <input type="checkbox"/> Cancer/ Tumor | <input type="checkbox"/> Asthma/ shortness
of breath | <input type="checkbox"/> Blackouts/fainting |
| <input type="checkbox"/> Severe night pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Orthopedic Injuries |
| <input type="checkbox"/> Bowel/ Bladder
problems | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Surgeries |
| | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other condition |

If you checked any of the above conditions, please take a moment to explain. _____

MEDICATIONS

Please list all medications you are currently taking _____

Rate your overall Health: Excellent Good Fair Poor

Please rate your ability to function on a 0-100% scale, with 0% being unable to do anything and 100% being completely normal in all aspects of your life: _____%

Please rate your **pain** on a scale of 0-10, with 0 being **no pain** and 10 being the **worst pain** you can ever imagine.

Now 0 1 2 3 4 5 6 7 8 9 10 Best 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10

Location of your pain: _____

Please choose the best word(s) to **describe your pain**

- Sharp Dull Aching Burning Stabbing Shooting Other _____

What makes your pain better? _____

What makes your pain worse? _____

Previous PT/OT/chiropractic or physician care this year? Yes ___ No ___ If YES, please explain _____

Occupation/Occupational Demands _____

Lifestyle/Exercise Routine _____

- Very Active/Athletic (5x/wk) Regular Exercise (1-3x/wk) Infrequent Exercise Sedentary

Goals for attending physical therapy _____