First Name: **Middle Initial:** **Last Name:**

Date of Birth: **Social Security Number:**

Gender:

Male Female Nonbinary Prefer Not to Say Prefer to Self-Describe

Mobile Phone: **Home Phone:** **Work Phone:**

Email Address:

Home Address:

Street: Unit:

City: State: Zip:

Marital Status:

Single Married Other

Emergency Contact:

Name:

Phone Number:

Relation to patient:

How did you hear about Reform?

- Doctor's Referral
- Friend / Family
- Website
- Google Search
- Social Media
- I've had PT at Reform in the past

First Name: **Middle Initial:** **Last Name:**

Are you a Medicare patient? Are you currently receiving home health care now, or within the past 60 days?

Primary Insurance:

Insurance Company:

Policy / Member ID:

Group Number:

Phone Number:

Are you the policy holder? YES / NO

Policy Holder Name: Policy Holder Relation to Patient:

Policy Holder DOB: Policy Holder Gender:

Policy Holder Employer: Employer Phone Number:

Secondary Insurance:

Insurance Company:

Policy / Member ID:

Group Number:

Phone Number:

Are you the policy holder? YES / NO

Policy Holder Name: Policy Holder Relation to Patient:

Policy Holder DOB: Policy Holder Gender:

Policy Holder Employer: Employer Phone Number:

First Name: **Middle Initial:** **Last Name:**

Date of Birth: **Height:** **Weight:**

Approximate date of injury or onset of pain:

Diagnosis as described by your physician:

What aspects of life are affected by your pain?

Have you received previous treatment? If yes, please describe.

Please indicate affected region(s):

- Head / Neck
- Arm
- Pelvis
- Leg
- Upper Back
- Lower Back
- Shoulder
- Hand / Wrist
- Hip
- Knee
- Other: (*please describe*)

439 Lewiston Road, Topsham, ME 04086 · *P: 207-725-4400 F: 207-725-4477*
23 Durham Road, Suite 101, Freeport, ME 04032 · *P: 207-869-4003 F: 207-869-4024*
45 Forest Falls Drive, Suite 1B, Yarmouth, ME 04096 · *P: 207-846-3300 F: 207-846-3315*
169 Port Road, Suite 21, Kennebunk, ME 04043 · *P: 207-204-0679 F: 207-204-0797*
Reform-PT.com

First Name: **Middle Initial:** **Last Name:**

Pain level over the last 24 hours:

1 2 3 4 5 6 7 8 9 10 (1= No pain, 10= Worst pain ever)

Have you fallen in the last year? If yes, how many times have you fallen?

Do you worry about falling? Do you feel unsteady standing or walking?

What kind of pain are you experiencing?

- Pain radiates down
- Tenderness
- Ache / Pain
- Pain radiates up
- Numbness / Tingling
- Other:

My pain symptoms are the BEST:

- In the morning
- During the day
- During the night
- At rest
- While active
- Other:

My pain symptoms are the WORST:

- In the morning
- During the day
- During the night
- At rest
- While active
- Other:

Are there other things we should know about your pain?

First Name: **Middle Initial:** **Last Name:**

Who is your referring doctor?

NAME:

OFFICE:

PHONE NUMBER:

Who is your Primary Care Physician?

NAME:

OFFICE:

PHONE NUMBER:

What are your goals for physical therapy?

Are you taking any medications? If yes, please list:

First Name: **Middle Initial:** **Last Name:**

Please indicate the condition(s) you have been or are currently receiving treatment for:

- Acquired Respiratory Distress Syndrome
- Allergies
- Angina
- Anxiety or Panic Disorders
- Arthritis
- Asthma
- Back Injury
- Bleeding Disorders
- Bowel / Bladder Abnormalities
- Cancer
- COPD (Chronic Obstructive Pulmonary Disease)
- Congestive Heart Failure
- Defibrillator
- Degenerative Disc Disease
- Depression
- Diabetes
- Dizzy or Fainting Spells
- Emphysema
- Epilepsy or Seizure Disorder
- Fracture
- Headaches
- Hearing Impairment
- Heart Attack
- Hepatitis A, B, C
- Hernia
- High Blood Pressure
- HIV / AIDS
- Hypoglycemia
- Immunosuppressant Condition or Medication
- Kidney Problems
- Liver / Gallbladder Problems
- Metal or Surgical Implants
- Multiple Sclerosis
- Nausea / Vomiting
- Osteoporosis
- Pacemaker
- Parkinson’s Disease
- Peripheral Vascular Disease
- Pregnancy
- Ringing in Your Ears
- Sexual Disfunction
- Skin Abnormalities
- Smoking
- Special Diet Guidelines
- Stroke or TIA
- Tuberculosis
- Upper Gastrointestinal Disease
- Visual Impairment

OTHER: