NORUM
PHYSICAL THERAPY
"The one to one experience"

Today's Date: _____

PATIENT INFORMATION

Last Name: _____ First: _____ Middle I:_____
Marital Status: (check one): ☐ S ☐ M ☐ D ☐ W
Street Address:_____
City:_____State:_____Zip code:_____
Home Phone:_____ Cell:_____DOB: _____Age:_____
Sex: ☐ F ☐ M SS#_____-_____-_____
Email address:_____ Occupation:_____
Employer:_____
Employer Address: _____
City:_____State:_____Zip code:_____
Emergency contact:_____ Phone number:_____
Drivers License #:_____

INSURANCE INFORMATION

Primary Insurance: _____Policy/Subscriber:_____
Policy ID#_____ Group #:_____
Address:_____City:_____State:_____Zip code:_____
Secondary Insurance: _____Policy/Subscriber:_____
Policy ID#_____Group #:_____
Address:_____City:_____State:_____Zip code:_____

MEDICAL QUESTIONAIRE

Primary Care Physician:_____Phone number:_____

Check any Medical Conditions listed that you are currently being treated for :

☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Asthma
☐ High/Low Blood Pressure
☐ Lung Issues
☐ Chest Pain
☐ Blurred Vision
☐ Balance Problems
☐ Deafness
☐ Tinnitus
☐ Fainting
☐ Stroke
☐ Anemia
☐ Epilepsy
☐ Angina
☐ Blood Clots
☐ Multiple Sclerosis
☐ Circulation Problems
☐ Eye infection
☐ Joint/Bone Infection
☐ Musculoskeletal Problems
☐ Tuberculosis
☐ Depression
☐ Heart Problems, Liver Problems,
☐ Pneumonia, Urinary Infection,
☐ Pacemaker

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List any Medical Conditions not stated above that pertain to you:

_____

_____

_____

Check Any Pertinent Family History:

☐ Cancer ☐ Diabetes ☐ Stroke
☐ HTN ☐ Cardiac Problems ☐ Lung Conditions

Do you have any allegies? ☐ Y ☐ N
List: _____
Are you pregnant? ☐ Y ☐ N ☐ N/A
Have you ever had surgery? ☐ Y ☐ N If yes, describe:

_____

List medications currently taking:

_____

Do you smoke cigarettes? ☐ Y ☐ N
Do you drink alcohol? ☐ Y ☐ N ____# of drinks/day,____Occasional/Social
Did someone refer you to this office? ☐ Y ☐ N If yes, please name that person or group:_____
Is your illness/injury related to an automobile accident? ☐ Y ☐ N Date:_____
Is your illness/injury work related? ☐ Y ☐ N Date:_____
Briefly describe the reason that brought you to this office:

_____

_____

What are your current chief complaints:

_____

_____

When did your present symptoms start?

_____

_____

Have you ever had a similar episode of this problem before?

_____

_____

What is your current level of Pain (scale 0-10; 0=nothing and 10=worst):_____

Have you ever had Physical Therapy before? ☐ Y ☐ N If so for what conditions:

_____

_____

_____

Patient or Guardian Signature:_____
Date:_____

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