PRO Sports Physical Therapy
2 Overhill Road, Suite 315
Scarsdale, NY 10583
(914) 723-6987

PATIENT INFORMATION

Last Name_____ First Name_____

Address_____ Apt #_____

City_____ State_____ Zip_____

Date of Birth_____/_____/_____ Sex: M____F____ Marital Status: S___M___D___W____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

Emergency Contact Name: _____Relationship:_____

Emergency Contact Phone (____) _____

Have you been treated at a different physical therapy this year? YES NO

Is this a Workers Comp or No Fault case? Please circle: WC NF

What was the date of the injury? _____

Did your injury occur while playing athletics at your school? If so, what school? _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company_____ ID or Policy Number _____

Address _____ City, State, Zip _____

Telephone Number _____ Contact Person _____

I acknowledge Receipt of Practice's Notice of HIPPA Privacy.

Signature of Patient/Parent/Guardian_____ Date_____

Patient Name: _____

Physician:_____ Date of surgery (if applicable):_____

Date of injury:_____ Height:_____ Weight:_____

Has there been imaging (X-ray, MRI, CT scan) for current condition? If so, please list: ____

_____

Other treatments for current condition (Chiropractic/Acupuncture/Epidural Injections):

_____

Other orthopedic conditions:_____

_____

Current medications (please list all with dosages or attach list):

_____

Any history of falls in the past 12 months?_____

_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ changes in bowel or bladder function	❑ weight loss/gain	❑ fever/chills/sweats
❑ nausea/vomiting	❑ shortness of breath	❑ pain at night
❑ dizziness/lightheadedness	❑ headaches	❑ weakness/fatigue
❑ difficulty maintaining balance while walking	❑ changes in appetite	❑ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer (type)_____	❑ rheumatoid arthritis	❑ diabetes
❑ heart disease	❑ stroke	❑ multiple sclerosis
❑ high blood pressure	❑ depression	❑ kidney/liver problems
❑ asthma	❑ anemia	❑ stomach ulcers
❑ pacemaker inserted	❑ lung problems	❑ epilepsy
❑ osteoporosis	❑ thyroid problems	❑ Parkinson's disease

Other medical conditions (hypertension, diabetes, etc. please list all):_____

_____