JIM WAMPLER rehab

Hands-on care that makes a difference in your life.

First:_______________ Middle Initial ____ Last Name: _______________ Date _______________

Social Security Number _______________ Age:________

Date of Birth: _______________ Home Phone:_______________ Alt. Phone: _______________

Street Address: _______________ City, State, Zip:_______________

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Other

Employer _______________ Employer Telephone Number _______________

Employer Address _______________

If name on insurance card is someone other than yourself, what is your relationship?_______________ Birthdate of subscriber?_______

Address of subscriber _______________

Emergency Contact/Relation to Patient/Phone #: _______________

Referring MD: _______________ Primary Care Physician: _______________

Was injury result of accident?_______________ If accident was it Auto or Workers Comp?_______________

Patient Medical History (Please check if you ever had or now have)

☐ Diabetes	☐ Osteoporosis	☐ Thyroid Problems	☐ Heart Attack
☐ Heart Disease	☐ Tuberculosis	☐ Asthma	☐ Circulatory Problems
☐ Arthritis	☐ High/Low Blood Pressure	☐ Hepatitis	☐ Other_______________
☐ Disability	☐ Convulsions/Seizures	☐ Pregnancy - Are you preganant currently? _______	
☐ Cancer	☐ Metal Implants	☐ Smoke/Chew Tobacco	
☐ Bleeding Tendency	☐ Pacemaker	☐ Stroke	

Height: _______________ Weight: _______________

List major surgeries you have had:_______________

____

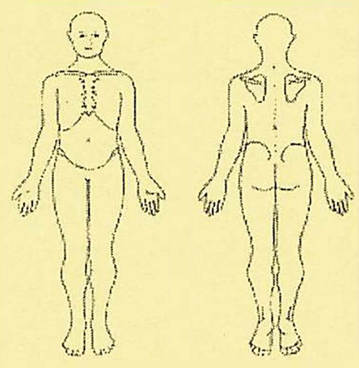
____

Current Medications:

____

____

Describe the chief complaint for which you are seeking therapy: _______________



When did you begin having pain/ symptoms: _______________
(Date)

When did you have surgery _______________
(Date)

Average pain intensity: at rest:

activity:

How did you find out about our clinic? ☐ I've been here before ☐ Doctor Recommended ☐ Newspaper ☐ Radio

☐ Friend/Relative Recommended - Name of Friend/Relative: _______________