

**New Mexico Sports Fitness & Physical Therapy, Inc.**  
Patient Medical History

**NEW MEXICO SPORTS FITNESS AND PHYSICAL THERAPY, INC.**  
**SUPPLEMENTAL PATIENT INFORMATION FORM**  
**(If patient returns for Physical Therapy within current year)**

Patient Name: \_\_\_\_\_

**I HAVE LISTED ANY CHANGES WITHIN PAST YEAR RE: MY PERSONAL INFORMATION BELOW:**

Old Address:

Current Address (w/I 6 mths)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Old Home  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Current Home  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Old Work  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Current Work  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Misc. Information: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient OR Parent of Minor**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

**CONSENT OF TREATMENT**

I consent and agree to treatment that is provided by New Mexico Sports & Physical Therapy, Inc.

\_\_\_\_\_  
**Signature of Patient OR Parent of Minor**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

**INSURANCE AGREEMENT**

I hereby instruct and direct my insurance carrier to make payment directly to New Mexico Sports & Physical Therapy, Inc. This is a direct assignment of my rights and benefits under this policy. I also authorize the release of any information pertinent to my case to my insurance carrier. A photocopy of this assignment and release shall be considered as effective and valid as the original.

\_\_\_\_\_  
**Signature of Patient OR Parent of Minor**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

**FINANCIAL AGREEMENT**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on this account for any services rendered at New Mexico Sports & Physical Therapy, Inc. I certify the information completed by to be true and correct. I agree to contact this facility regarding any information changes, which may affect the status of my account.

\_\_\_\_\_  
**Signature of Patient OR Parent of Minor**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

**1. Please list any changes to your medications?**

Medications a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

**History of Present Illness**

2. How did your problem start? Suddenly\_\_\_ Slowly over time\_\_\_ During Sports\_\_\_ At work\_\_\_  
(Please check all that apply) Fall\_\_\_ Lifting\_\_\_ Pulling\_\_\_ Auto Accident\_\_\_ No cause\_\_\_

3. What are your symptoms? Pain\_\_\_ Swelling\_\_\_ Redness\_\_\_ Bruising\_\_\_ Spasm\_\_\_  
(Please check all that apply) Weakness\_\_\_ Tingling\_\_\_ Locking\_\_\_ Catching\_\_\_ Give way\_\_\_

4. If you have pain, describe it. Constant\_\_\_ Intermittent\_\_\_ While at rest\_\_\_ At night\_\_\_  
(Please check all that apply) With activity\_\_\_ Burning\_\_\_ Aching\_\_\_ Sharp\_\_\_ Dull\_\_\_

5. On average, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10  
no pain worst pain

6. What reduces your symptoms? Sitting\_\_\_ Lying down\_\_\_ Stopping activities\_\_\_ Standing\_\_\_  
(Please check all that apply) Walking\_\_\_ Medication\_\_\_ Physical Therapy\_\_\_ Ice\_\_\_ Heat\_\_\_

7. What makes your problem worse? Sitting\_\_\_ Standing\_\_\_ Walking\_\_\_ Bending\_\_\_ Cough/Sneeze\_\_\_  
(Please check all that apply) Exercise (during)\_\_\_ Exercise(after)\_\_\_ Other\_\_\_\_\_

**Social History**

8. What is your occupation? \_\_\_\_\_ Employer \_\_\_\_\_

9. Do/did you use tobacco? YES\_\_\_ NO\_\_\_ How much? \_\_\_\_\_ Quit when? \_\_\_\_\_

10. Do you drink alcoholic beverages? YES\_\_\_ NO\_\_\_ How many drinks per day? \_\_\_\_\_

11. Have you ever been addicted to prescription or non-prescription drugs? YES\_\_\_ NO\_\_\_ Which? \_\_\_\_\_

12. Do you live alone? YES\_\_\_ NO\_\_\_

13. How often do you exercise? Never\_\_\_ Rarely\_\_\_ Monthly\_\_\_ Weekly\_\_\_ Daily\_\_\_

What type of exercise? \_\_\_\_\_

14. Which is your dominant hand? RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_ BOTH \_\_\_\_\_

**Miscellaneous**

15. Were you referred here by a physician? YES\_\_\_ NO\_\_\_ Name \_\_\_\_\_

16. Who is your primary care physician? Name \_\_\_\_\_

17. Is there any legal action pending that pertains to your visit? YES\_\_\_ NO\_\_\_

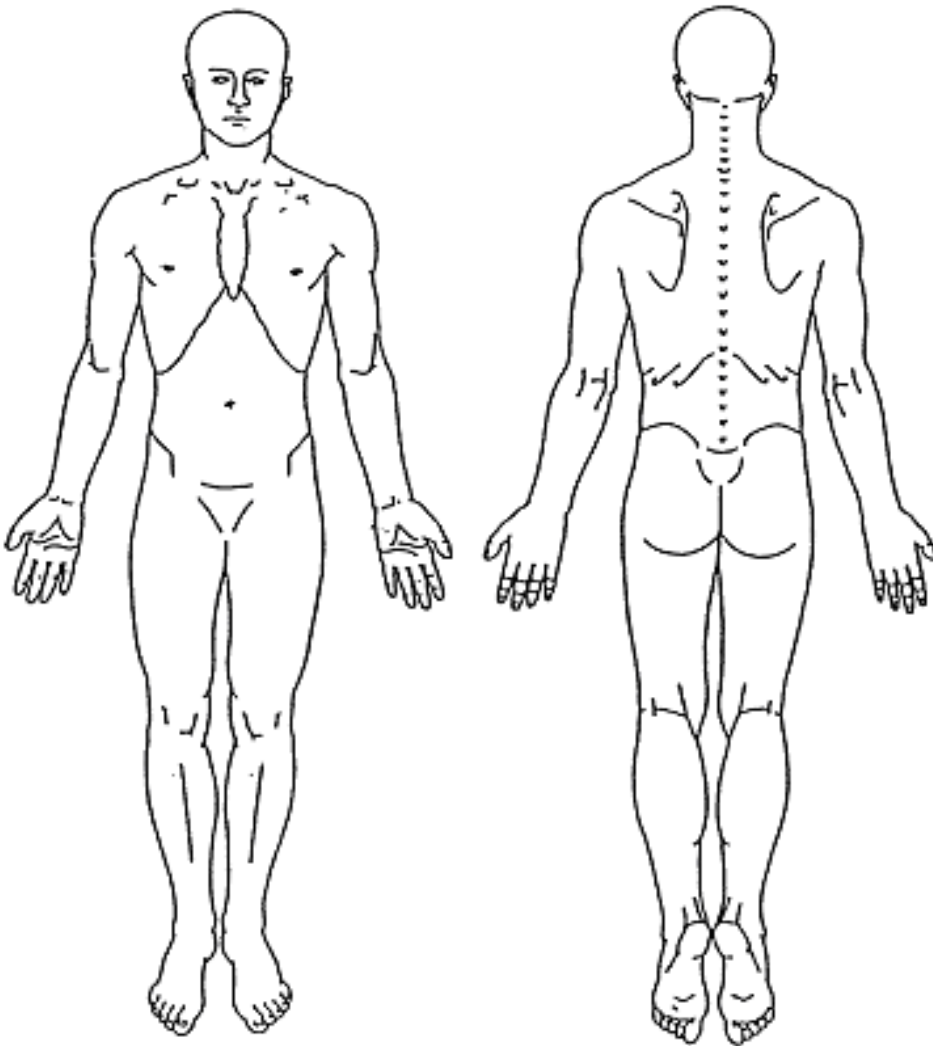
Describe \_\_\_\_\_

**What would you like to accomplish with Physical Therapy \ Occupational Therapy?**

- Return to hobby/recreation /sport
- Return to work
- Improve strength and motion
- Decrease pain
- Improve daily function
- Other: \_\_\_\_\_

**What is the date that you return to the doctor? \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Please shade the area(s) below where your symptoms are located:**



**If you have pain, please write the intensity between 0-10 next to the shaded area.  
(0=No Pain, 5=Moderate Pain, 10=Severe Pain)**

\_\_\_\_\_  
Signature of patient or parent of minor

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date