NEXT GENERATION
PHYSICAL THERAPY

Current Problem **Date** ______________

Name (First, MI, Last) ______________________________

____

Date of Birth ______________ **Age** ________ ☐ Male ☐ Female

Primary Care Physician ______________________________

Referring Physician ______________________________

Height (feet/inches) ________ **Weight (lbs.)** ________ ☐ Right Handed ☐ Left Handed ☐ Both

Current Problem: ☐ Right ☐ Left ☐ Both **Numbness:** ☐ Right ☐ Left ☐ Both

☐ Shoulder ☐ Hand ☐ Mid Back ☐ Foot ☐ Lower Leg ☐ Upper Arm
☐ Finger ☐ Lower Back ☐ Ankle ☐ Upper Back ☐ Elbow ☐ Thumb
☐Hip ☐Knee ☐Forearm ☐Neck ☐Thigh ☐Wrist
☐ **Other (describe)** ______________________________

Date of Injury/Onset of problem (if known): ______________________________

Describe how and where injury occurred: ______________________________

____

Describe Severity of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Night Pain

Does the Pain Radiate: ☐ Yes ☐ No **If Yes, radiates to (describe)** ______________________________

Quality of Pain: ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐Throbbing ☐ Other

Since Problem Started is it: ☐ Getting Better ☐ Getting Worse ☐ Improving ☐ No Change

What makes symptoms better: ☐ Rest ☐ Heat ☐ Elevation ☐ Ice ☐ Other ______________

What make symptoms worse: ☐ Bending ☐Lifting ☐Squatting ☐Standing ☐Twisting ☐Stairs
☐Walking ☐Pushing ☐ Exercise ☐ Lying in Bed ☐Coughing ☐Sneezing ☐Other

Prior Treatment for this Problem: ☐ Medication ☐ Physical Therapy ☐ Steroid Inj. ☐ Cast ☐ Surgery ☐ Other

Prior Diagnostic Tests: {Have you ever had any of the following, if so, when and where?}
☐ X-ray ☐ CT Scan ☐ MRI ☐ Other ☐ Pre-existing condition

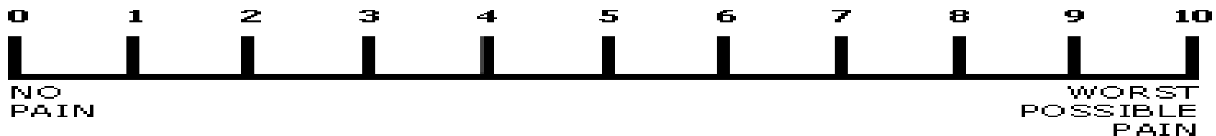
Pain Drawing Grid Assessment

Using the abbreviations below, please draw the location of your pain on the body outline and mark the severity of your pain on the pain scale at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
//////	BBBBBBB	XXXXXXXXX	………………………	ZZZZZZZZ	OOOOO

FRONT

BACK



NEXT GENERATION PHYSICAL THERAPY

I have indicated that Next Generation Physical Therapy (MAY/MAY NOT) leave appointment information on my voice mail.

The following people listed below may have access to my personal health information and/or

Communicate with medical staff regarding my healthcare treatment.

Coach's: ____

Athletic Trainers: ____

Others: ____

_______ Check here if you would not like anyone listed.

Patient information:

Name: ____

Address: ____

Phone number: ______________________________

Date of Birth: _______________________________

I acknowledge that I have been offered a copy (posted in lobby) of Notice of Privacy Policies dated September 2015.

X ____Date: ______________________

Patient signature or legal guardian

For Staff Use Only

_______ Patient received notice, but refused to sign.

2800 South 2nd St.

Cabot, AR. 72023

(501)286-6059

Primary Care Physician		Referring Physician		Date of Injury

PATIENT INFORMATION

Patient Name	Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	
Social Security Number	Date of Birth	Age	Sex ☐ M ☐ F
Physical Address, City, State and Zip Code			
Billing Address, City, State, and Zip Code			
Home Phone Number	Cell Phone Number	Email Address	
Employer Name		Employer Phone Number	
Employer Address, City, State, and Zip Code			
Insurance carrier Primary:	ID#		
Insurance carrier Secondary:	ID#		

Is this visit the result of a Workers' Compensation?	☐ Yes	☐ No
If YES, did you file a Worker's Compensation Claim?	☐ Yes	☐ No
Is this visit the result of a Motor Vehicle Accident?	☐ Yes	☐ No
If YES, is there an attorney representing you?	☐ Yes	☐ No

RESPONSIBLE PARTY

Name: (Last, First, MI)	Phone Number	Social Security	Date of Birth
Address, City, State and Zip Code			

EMERGENCY CONTACT

Name:	Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Next Generation Physical Therapy to release any information required of my insurance company to process and pay my claims.

______________________________ ______________

Patient/Guardian Signature Date

DO YOU HAVE, OR DID YOU EVERHAVE, ANY OF THE FOLLOWING?

Cardiovascular:

YES/NO

- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Disease from Childhood
- ☐ ☐ Heart Murmur
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Use of Phen-Fen
- ☐ ☐ Pacemaker
- ☐ ☐ Vascular Graft
- ☐ ☐ Heart Valve Replacement
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Surgery
- ☐ ☐ Congestive Heart Failure
- ☐ ☐ Angina (chest pain)
- ☐ ☐ Irregular Heart Beat
- ☐ ☐ Stroke
- ☐ ☐ Increased Cholesterol

Respiratory:

YES/NO

- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis
- ☐ ☐ Other

Endocrine/Hematologic/ Oncologic/Immune:

YES/NO

- ☐ ☐ Diabetes
- ☐ ☐ Thyroid Disease
- ☐ ☐ Hemophilia
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Bleeding Tendency
- ☐ ☐ Anemia
- ☐ ☐ Cancer
- ☐ ☐ Radiation Therapy
- ☐ ☐ Chemotherapy
- ☐ ☐ HIV infection/AIDS
- ☐ ☐ Organ Transplant
- ☐ ☐ Blood Transfussion

GI/GU:

YES/NO

- ☐ ☐ Hepatitis (A,B,C,or other?)
- ☐ ☐ Kidney Dialysis
- ☐ ☐ Ulcers
- ☐ ☐ Sexually Transmitted Disease
- ☐ ☐ Denied Permission to give Blood

Musculo-Skeletal/CNS/Development:

YES/NO

- ☐ ☐ Joint Replacement
- ☐ ☐ Osteoarthritis
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Spinal Cord Injury
- ☐ ☐ Seizures
- ☐ ☐ Cerebral Palsy
- ☐ ☐ Mental Retardation
- ☐ ☐ Dementia

Psychological:

YES/NO

- ☐ ☐ Anxiety/Nervousness
- ☐ ☐ Depression
- ☐ ☐ Mental Health Treatment
- ☐ ☐ Eating Disorder

Social:

YES/NO

- ☐ ☐ Do you use Tobacco Products?
- ☐ ☐ Do you Drink Alcohol?
- ☐ ☐ Every Day? If so, how much?
- ☐ ☐ Do you use recreational drugs?

Medications:	Dosage:	Oral/Injection:	Frequency:	Reason:

Have you had any falls in the last 12 months? ____________________

If so, how many: ____________________

Reason for fall: ____________________

NEXT GENERATION PHYSICAL THERAPY

PHOTO RELEASE FORM

I, the undersigned, do hereby grant permission to the Next Generation Physical Therapy to use the image of my child or myself, ________________________________. Such use includes the display or use of photographs taken of my child or myself for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, and digital images such as those on the Next Generation web site.

I give unrestricted permission for my child or my self's image to be used in print and digital media. I agree that these images may be used by the Next Generation Physical Therapy for a variety of purposes and that these images may be used without further notifying me. I do understand that the child will not be identified in conjunction with any images without obtaining additional consent to do so.

Please check below to allow us to use your name and photo.

______ uses your name

______ uses your photo

Parent/individual signature ______________________________________ Date ___________________