New Patient Form

7478 SW 60th Ave Unit A Ocala, FL 34476 Ph: (352)433-1918 Fax: (352)433-0950

DEMOGRAPHICS

First Name	
Middle Initial	
Last Name	
Nickname	
Birth Date	_____/_____/_____ (mm/dd/yyyy)
Sex	Male Female
Marital Status	Single Married Widowed
Address Line	
City	State: Zip:
Telephone	Home: Cell:
Email Address	
Emergency Contact	Full Name / Relationship / Phone# ( )
Next appointment date with the MD that referred you:	

Home Health OR Previous PT/OT/Chiro	Have you had Home Health this year? YES ☐ NO ☐ If so, are you fully discharged? _____ D/C Date: _____ Have you already had PT, OT and/or Chiropractic in 2025? _____ If yes, approx how many visits? _____

Please present your Prescription Form, Driver's License and Insurance Cards at check-in.
We will scan and return them to you immediately.

HISTORY OF PRESENT ILLNESS:

This form must be fully completed – Only leave blank if does not apply.

REASON **your doctor referred you: _____**

WHEN **did your current condition start?: _____**

Did you have surgery for this condition: Yes ☐ **Date of surgery_____** NO ☐ N/A ☐

Mark the number that best corresponds to your pain level:

TODAY's Pain Level:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐(Excruciating = calling 911)

At Worse:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (Excruciating = calling 911)

At Best:

0 ☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐ (Excruciating = calling 911)

Are your symptoms:

Constant ☐ OR Intermittent ☐

Has your condition been getting:

Better ☐ Worse ☐ Same ☐

Have you received previous treatments for this condition? {CHECK ALL THAT APPLY}

Physical Therapy ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Injections ☐ Dry Needling ☐

What makes your pain *BETTER*? {CHECK ALL THAT APPLY}

Bending ☐ Sitting ☐ Heat ☐ Lying down ☐

Change position ☐ Standing ☐ Ice ☐ Walking ☐

Rest ☐ Stretching ☐ Medication ☐ Nothing helps ☐

What makes your condition *WORSE*? {CHECK ALL THAT APPLY}

Bending ☐ Rising ☐

Lifting ☐ Sitting ☐ Lying on affected side ☐

Movement ☐ Standing ☐ Coughing/Sneezing ☐

Reaching ☐ Walking ☐

List Surgeries that are pertaining to the condition we are treating:

_____

_____

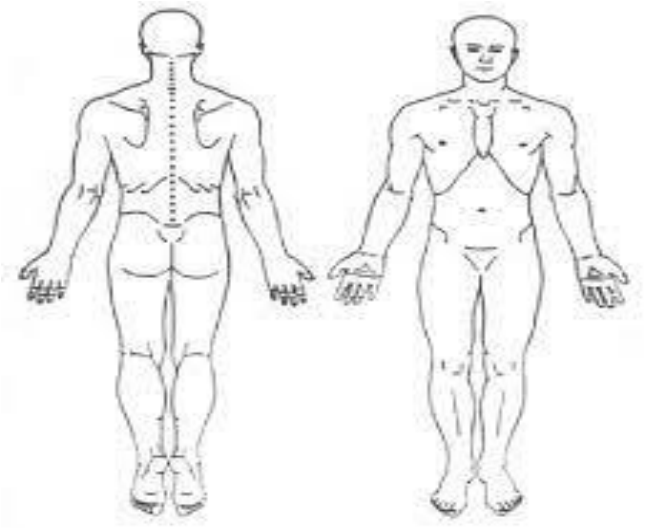
_____

Have you fallen in the past year?

Yes ☐ No ☐ If yes, how many times?_____

Any injuries from falling?_____

MARK ON DIAGRAM AREAS OF PAIN / SYMPTOMS



Medical Information {MARK ALL THAT APPLY}

__Diabetes	__Pacemaker	__HIV/Hepatitis	__Arthritis
__Osteoporosis	__Stroke	__Thyroid Disorder	__Fibromyalgia
__High Cholesterol	__Blood Clots	__COPD	__Pregnant now
__High Blood Pressure	__Depression/Anxiety	__Asthma	__HIV/Hepatitis
__Heart Disease	__Fever/Chills/Sweats	__Shortness of Breath	__ Epilepsy/Seizures

CANCER: Prostate☐ Breast ☐ Other_____ Active:_____

"No Shows"	Due to the large block of time needed for each patient's treatment, last-minute cancellations can cause problems and added expenses for our clinic. If your appointment is not cancelled within 24hrs, a $35 charge (which is not covered by your insurance company) will be due at your next visit. Acknowledged -> _____ (please initial here) **Even if you do not initial you still will be responsible** After 3 No shows you will be discharged from therapy.
Consent to Treat	I have provided my information truthfully and have read all the above information and authorize Empower Physical Therapy to perform services and seek payment in accordance with the provisions here within. **Patient Signature:**_____ **Date:**_____