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**NEW PATIENT INFORMATION:**

Today's Date: \_\_\_\_\_

Patient's Full Legal Name – please provide a copy of your driver's license or other photo identification

\_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ email : \_\_\_\_\_

Patient Status: (check one) Single: \_\_\_ Married: \_\_\_ Other: \_\_\_  
Employment Status: (check one) Employed: \_\_\_ Retired: \_\_\_ Full-time student: \_\_\_

Employer's Name and address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Physician Phone number \_\_\_\_\_

Physician address \_\_\_\_\_

Reason for seeking Physical Therapy (Diagnosis) \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Primary insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

Please provide a copy of your insurance card

Name of Covered Employee: \_\_\_\_\_

Employer Providing Primary Insurance: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City, State, Zip

Relationship to Patient: Self \_\_\_ Spouse \_\_\_

If Spouse, please provide: Spouse's name \_\_\_\_\_

Spouse's SS# \_\_\_\_\_ Spouse's Birthday \_\_\_\_\_

Secondary insurance \_\_\_\_\_

Medical history

Please give a brief description of the condition you are coming to physical therapy about.  
How did it start? When did it begin?

\_\_\_\_\_

\_\_\_\_\_

Is your condition: Getting worse \_\_\_\_\_ Getting better \_\_\_\_\_ Staying the same \_\_\_\_\_

Past treatment or tests for this condition: \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Current medications:

Name of drug	Reason for taking it	Name of drug	Reason for taking it
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		Continue on back if needed	

Please list all surgeries: \_\_\_\_\_

Allergies: Latex \_\_\_\_\_ Rubbing alcohol: \_\_\_\_\_ Other: \_\_\_\_\_

Please check all that apply:

Heart disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Scoliosis (curve of the spine)	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	Back / neck pain	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	Parkinson's / Alzheimer's	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>
Lung disease, asthma	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	Difficulty urinating in public	<input type="checkbox"/>
Chronic coughing	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>
TB	<input type="checkbox"/>	Urinary or fecal leakage	<input type="checkbox"/>	Others, please list:	<input type="checkbox"/>
Sexual transmitted disease	<input type="checkbox"/>	Painful intercourse	<input type="checkbox"/>		<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>		<input type="checkbox"/>

In general would you say your health is – very good                  good                  fair                  poor

Social history

Do you live: Alone \_\_\_\_\_ With a spouse \_\_\_\_\_ With others \_\_\_\_\_

Number of children living with you: \_\_\_\_\_ Ages \_\_\_\_\_

Do exercise on a regular basis? What type? \_\_\_\_\_

Amount of stress(circle one):

At home      low      medium      high  
At work      low      medium      high

Do you feel safe in your home? \_\_\_\_\_

We will discuss your history completely during the first visit. Is there any other history you would like to tell me about?

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

