Sherwood Crossing
7910 Andrus Road, Suite 5
Alexandria, VA 22306
Phone: (571) 481-4547

MOUNT VERNON
PHYSICAL THERAPY

NEW CASE PATIENT INFORMATION	
Last Name:	First Name:
Referring Doctor:	Next Scheduled MD Appt:

Do you have an outgoing 3rd party litigation for this condition?

☐ No

☐ Yes (circle one please) Employment Automobile Accident

Have you had any prior Physical Therapy/Occupation/Speech Therapy since your last visit at MVPT?

☐ No

☐ Yes, Dates of treatment: _____

Any changes to your personal and/or insurance information since your last visit at MVPT?

☐ **No, please skip New Address and New Insurance information section.**

☐ **Yes, please complete the New Address and New Insurance information section.**

NEW ADDRESS/PHONE # INFORMATION		
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:

NEW PRIMARY INSURANCE INFORMATION *(only complete if you are <u>not</u> insurance subscriber)*	**NEW SECONDARY INSURANCE INFORMATION** *(only complete if you are <u>not</u> insurance subscriber)*
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:
Relation to Patient:	Relation to Patient:

Turn Over

MEDICAL SCREENING

PAIN SCALE LAST 48 HOURS											
Where is your pain?											
Describe your pain?											
Worst level of pain (Please circle)	0	1	2	3	4	5	6	7	8	9	10
Current level of pain (Please circle)	0	1	2	3	4	5	6	7	8	9	10
Best level of pain (Please circle)	0	1	2	3	4	5	6	7	8	9	10

Do you feel emotionally and physically safe at home/work? _____

Do you have worrying thoughts going through your mind a lot of the time? _____

FALL RISK INTAKE

Have you fallen in the past year? ☐ No ☐ Yes, date(s): _____

PAST MEDICAL HISTORY

Do you have any updates to your medical history since your last visit at MVPT?

☐ No

☐ Yes, please list:

_____

_____

_____

_____

Have you had any tests done related to your symptoms? (Check)

☐ No ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ Blood Test

Medication, Vitamins & Supplements

Please list all medications including **frequency** and **dosage**: (both over-the-counter and prescribed)

Name	**Dosage**	**Frequency**	**Route of Administration (Circle one)**			
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections

Patient/Legal Guardian Signature: _____ Date:_____