Newton Therapy
& Sports Performance
NEWTON MEDICAL CENTER

510 E Wheatridge Drive | Newton, KS 67114
Phone 316-836-4700 | Fax 316-836-4750

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____
Date of Birth: _____ SSN#: _____
Home address: _____ PO BOX: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Gender at birth: ☐M ☐F Current Gender Identification: _____
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed
Race: ☐African American ☐Asian/Pacific Islander ☐Caucasian ☐Hispanic ☐Native American ☐Other
Ethnicity: ☐Hispanic ☐Non-Hispanic Preferred Language: ☐English ☐Spanish ☐Other
Email: _____ Employer: _____
Occupation: _____ Work Phone: _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Provider: _____ Phone Number: _____
Referring Provider: _____ Phone Number: _____
Is this a DIRECT ACCESS (no referral) visit? ☐Y ☐N

EMERGENCY CONTACT INFORMATION

By listing the individual below as an emergency contact, you are authorizing our staff to release information regarding the nature of the emergency and your location.

Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

No need to fill this out if insurance card is presented at time of your initial evaluation.

Insurance Provider: _____
Insurance Phone Number: _____
Insurance Address: _____
Policy # _____ Group # _____
Policy Holder Name: _____ DOB: _____
Policy Holder Relationship to patient: _____

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RESPONSIBLE PARTY/ GUARANTOR INFORMATION

Please complete if patient is under the age of 18 or if you would like billing information sent to someone other than the patient.

Name: _____ Relationship: _____
SS#: _____ Guarantor DOB: _____
Home address: _____ PO BOX: _____
City: _____ State: _____ Zip: _____
Contact Number: _____ Employer: _____

RELEASE OF INFORMATION

By listing the following names, you are granting permission for us to share your information with them.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Do you grant us permission to leave messages for you regarding your healthcare or appointments on your phone voicemail? ☐Y ☐N
Do you grant us permission to send text messages regarding upcoming appointments? ☐Y ☐N
Number to text: (_____)_____

X _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

CANCELLATION POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. We understand that unavoidable circumstances may cause you to cancel within 24 hours, and these situations will be considered on a case by case basis.

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. Patients that NO SHOW two (2) times will be subject to a $50.00 fee. Patients who NO SHOW three (3) times may be dismissed from the practice, thus they will be denied further appointments. The No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Fees may be paid with cash or credit card. Please sign that you have read, understand, and agree to this Cancellation and No Show policy.

X _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

If you would like a copy of the Cancellation and No Show policy to retain for your personal records, please let the receptionist know.

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PROBLEM AND/OR ACCIDENT & INJURY

Is this visit a result of an accident or an injury? ☐Y ☐N
If this is an injury was it due to: ☐ motor vehicle accident ☐ worker's compensation ☐ other
If this was an injury, how did it occur? _____Date: _____
Where did the injury take place (city/state)? _____ Time _____
Is there legal action pending related to your problem? ☐Y ☐N
Have you had any treatments or tests for this injury prior to today's visit? ☐Y ☐N
☐ X-Rays ☐ MRI ☐ Bone Scan ☐ Nerve Conduction Testing ☐ Other

HISTORY OF PRESENT ILLNESS

Body part being seen for today: _____ ☐ LEFT ☐ RIGHT
Please rate your pain on a scale of 0-10, 10 being the worst: _____
How long have you had this pain? _____ ☐ day(s) ☐ week(s) ☐ month(s) ☐ year(s)
Describe your symptoms: _____
How does your pain feel? ☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Throbbing ☐ Other
How often do you have pain? ☐ Consistent ☐ Intermittent ☐ Occasional ☐ Rare ☐ Other
Does your pain radiate? ☐ Y ☐ N Radiates to where? _____
Is your pain aggravated by:

☐ Nothing	☐ Pulling	☐ Weight Bearing	☐ Squatting
☐ Lifting	☐ Throwing	☐ Walking	☐ Bending
☐ Overhead Motion	☐ Weather	☐ Running	☐ Prolonged Sitting
☐ Pushing	☐ Movement	☐ Stairs	☐ Other _____

Treatments that you have tried for current problem:

☐ Nothing	☐ Tylenol	☐ Physical Therapy	☐ Crutches
☐ Rest	☐ Ibuprofen	☐ Brace	☐ Chiropractor
☐ Ice	☐ Aleve	☐ Cast	☐ Injections
☐ Heat	☐ Home Exercise Program	☐ Splint	☐ Meds

IF YOU ARE A STUDENT:
What sports do you plan on playing this year?

_____

_____

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New Patient Medical History - NMC Outpatient Therapy

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Current Medications (please list over-the-counter, vitamins and herbs)

Medication Name	Strength (mg)	Quantity (ex. 2 tablets)	Times/day

Personal Medical History (current and prior) CIRCLE ALL THAT APPLY

Cardiovascular

Angina (Chest Pain)
Atrial Fibrillation
Congenital Heart Defects
Congestive Heart Failure (CHF)
Coronary Artery Disease
Heart Attack
Heart Stents
High Blood Pressure
High Cholesterol
Pacemaker
Peripheral Artery Disease

Cancer

Type:
Treatment:

Endocrine

Adrenal Disease
Diabetes- Type 1/Type II
Thyroid Disease

Vision

Blindness
Cataracts
Glaucoma
Macular Degeneration

Stomach/Bowel/Liver/Kidney

Liver Disease/Cirrhosis
Colon Polyps
GERD (acid reflux)
Inflammatory Bowel Disease (IBS)
Stomach or Duodenal Ulcers
Kidney Disease/Dialysis

Hematologic / Infectious

AIDS/HIV
Anemia
Bleeding Disorder
Blood Clots / DVT / PE
Hepatitis – Type
MRSA Infection

Mental Health

Anxiety
Depression

Muscular/Skeletal

Bone/Muscle Disorder
Osteoarthritis
Rheumatoid Arthritis
Osteoporosis

Neurological (Nerve/Brain)

Migraine Headaches
Neuropathy
Seizure Disorder/Epilepsy
Stroke
Tremor/Balance Disorder

Respiratory (Lungs)

Asthma
Bronchitis or Pneumonia
COPD/Emphysema
Obstructive Sleep Apnea

Surgical History

Date	Procedure	Physician	Hospital

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