NMC health®
PO Box 308 | Newton, KS 67114

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 Health PT & Rehabilitation
510 E. Wheatridge Drive, Newton KS 67114

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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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