677 Ala Moana Blvd. • Suite 725 • Honolulu, HI 96813
Phone: 808.734.0010 • Fax: 808.734.0013

Today's date: ____________

Legal Name: ______________________ Sex: Male / Female

Street Address: ______________________

City: ____________ State: ______ Zip Code: ______

Mailing Address *if different:* ______________________

Home Phone: (   ) ______ - ______ Work Phone: (   ) ______ - ______

Marital Status: M S D W **Birth Date:** / /

Employer: ____________ Current Status: Full time / Pt time / Off work

Date of injury or how long you have had problem: ______ Date of surgery: ______

Referring Physician: ______ Primary Care Physician: ______

Emergency Contact: ______ Phone Number: (   ) ______ - ______

INSURANCE: Is this an on-the-job injury? ☐ Is this an auto injury? ☐

Insurance Carrier Name: ______________________

Claim Number: ______ or Patient's Soc. Sec. # ______

If Auto Insurance, Insured's name ______

If on the job, employer at time of injury ______ Phone: ______

If patient is a minor (18 or under):

Parent/legal guardian name: ______

Address (*If different from above*): ______ Phone: ______

DOB: ____ / ____ / ____ Employer: ______ Phone: ______

ALL COPAYS ARE DUE AT TIME OF VISITS

***More on the back of the page**

MEDICAL HISTORY (Pertaining to your visit in our clinic)

Are you aware of your current diagnosis? Yes ____________ No ________

Have you sought previous therapy for this condition? Yes ________ No _________

Have you had any physical therapy visits for this calendar year? Yes ___________ No _________

Specific pain area? ____

Previous Surgeries? ____

Current Medications? ____

Do you smoke? ________ How many packs per day? ______________

Do you drink alcohol? _________ Average daily intake? __________________

Please check any/all of the following conditions that apply to you either currently or in the past with a check mark and those that apply to any immediate family member with an F:

___ High Blood Pressure	_______ Chemical Dependency	_______ Kidney Disease	_______Heart Attack
___ Diabetes	_______ Hepatitis	_______Chest Pains	_______Heart Surgery
___ Dizziness/Fainting	_______Tuberculosis	_______Depression	_______Gout
___Thyroid Problems	_______Varicose Veins	_______Arthritis	_______Cancer
___Emphysema	_______ Stroke	_______HIV/AIDS	_______MRSA