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:* ____

Cell Phone: (____)_____-______ **Home Phone:** (____)_____-______ **Work Phone:** (____)_____-______

(Disclaimer: Adding a work number allows us to call this number)

Email: ____________________________________ **Appointment Reminders?** ☐ Text ☐ Email

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Marital Status: M S D W **Birth Date:** ___/____/_____

Employer: ____________________________ Current Status: Full-Time / Part-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: ________________________ If Auto Insurance, Insured's name: ________________

If on the job, employer at time of injury: ________________________ Phone: (____)______-________

If patient is a minor (under 18):

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? ______________

Do you have allergies? ☐ Yes ☐ No if yes, please list: ______________________________

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

☐ By checking this box, I declare that all information provided on this form is accurate and up-to-date.

__________ ______________

Initials Date