MCOPT | McKENZIE CROSSING
ORTHOPEDIC PHYSICAL THERAPY

**Name**:_____ **DOB**:_____ **Gender**: Male/Female

**Mailing Address**:_____

**Street Address**:_____

**City**:_____ **State**:_____ **Zip Code**:_____

**Home #**_____**Cell #**_____

**Work #**_____ **OK to call? Yes / No**

**Email:** _____**Marital Status**: Single--Married--Divorced--Widowed

**Employer**:_____**Work Status**: Full time--Part time--Not working--Retired

**Emergency Contact**:_____**Phone #**

_____

**If patient is a minor (18 or under):**
Parent/Legal Guardian Name:_____Phone #_____

**MEDICAL HISTORY**

**Previous therapy for this condition**? Yes / No

**Where**?_____ **# of visits**

_____

Rate your worst pain in the **last 24 hours**: (no pain) 0—1—2--3--4—5—6—7—8—9--10 (severe pain)

Previous Surgeries (related to today's visit):_____

Current Medications:_____

**Please CHECK** any/all of the following conditions apply to you currently or have in the past with a CHECK MARK and those that apply to immediate family members with an F:

| | | | |
|---|---|---|---|
| ___High Blood Pressure | ___Chemical Dependency | ___Kidney Disease | ___Hepatitis |
| ___Varicose Veins | ___Heart Surgery | ___Chest Pains | ___Heart Attack |
| ___Dizziness/Fainting | ___Tuberculosis | ___Depression | ___Thyroid Problems |
| ___Diabetes | ___Gout | ___Arthritis | ___Emphysema |
| ___Epilepsy/Seizures | ___Stroke | ___Cancer | |