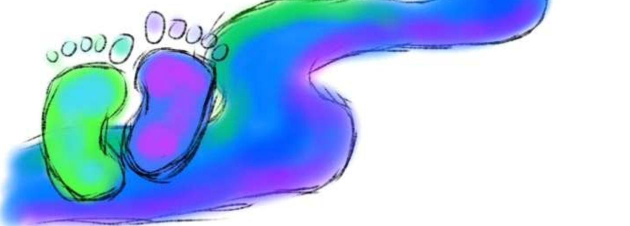

7011 Gum Branch Road
Richlands, NC 28574
Phone: (910) 430-2201
Fax: (910) 324-4325
Fax: (888) 653-7243
Email: prosteptherapy@gmail.com

Patient Name: ______________________ Today's Date: __________

Address: ______________________ Date of Birth: __________

______________________ Current Age: __________

Circle the Best Phone # to Contact Home: __________ Height: __________

Cell: __________ Other: __________ Weight: __________

Text for Appointment Reminders: Yes No Email: __________

Parent(s)/Guardian(s) OR Emergency Contact(s): __________

Relationship to Patient: __________ Phone Number(s): __________

Insurance Co: __________ Policy #: __________

Insurance Group #: __________ Policy Holder Name: __________ DOB: __________

Primary Medical Facility: __________ Physician Name: __________

Office Location: __________ Referring Provider (if diff): __________

Reason for Referral and any other concerns you may have: __________

____

____

Past Medical Info/History: __________

____

____

Please list any Medical Diagnosis: __________

Please list any Allergies: __________

Please list any current medications you are taking (use the back of this page if you need more space):

Drug	Dosage	Frequency	Route (oral, topical, injection etc)	Reason taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Patient Name: ______________________________ DOB ______________

Please circle yes/no to any of the following that apply to currently or in the past:

Allergies	Yes	No	Diabetes	Yes	No	MRSA	Yes	No
Anemia	Yes	No	Dizzy Spells	Yes	No	Multiple Sclerosis	Yes	No
Anxiety	Yes	No	Emphysema/Bronchitis	Yes	No	Muscular Disease	Yes	No
Arthritis	Yes	No	Fibromyalgia	Yes	No	Osteopenia	Yes	No
Asthma	Yes	No	Fractures	Yes	No	Rheumatoid Arthritis	Yes	No
Autoimmune Disorder	Yes	No	Headaches	Yes	No	Seizures	Yes	No
Cancer	Yes	No	Hearing Impairment	Yes	No	Speech Problems	Yes	No
Cardiac Conditions	Yes	No	Hepatitis	Yes	No	Strokes	Yes	No
Cardiac Pacemaker	Yes	No	High/low blood Pressure	Yes	No	Thyroid Disease	Yes	No
CMV (cytomegalovirus)	Yes	No	HIV/AIDS	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Incontinence	Yes	No	Vision Problems	Yes	No
Depression	Yes	No	Kidney Problems	Yes	No	OTHER	Yes	No

Please explain any circled yes: ______________________________

____

____

FOR PEDIATRIC OR ADOLESCENT PATIENTS, PLEASE COMPLETE THE FOLLOWING:

Were there any complications during your pregnancy or during your child's birth? ______________________________

____

____

Was your child born prematurely? (If yes how many weeks early) ______________________________

Please indicate if your child is able to do the following. If yes, list the age this occurred (or approximate if unsure):

Bringing Hands to Mouth	Yes	No	Age:	Catching a Ball	Yes	No	Age:
Grabbing a Toy	Yes	No	Age:	Potty Trained	Yes	No	Age:
Holding Head Up Alone	Yes	No	Age:	Writing Name	Yes	No	Age:
Rolling Over	Yes	No	Age:	Tying Shoes	Yes	No	Age:
Sitting w/out Assistance	Yes	No	Age:	Babbling	Yes	No	Age:
Crawling	Yes	No	Age:	Saying First Words	Yes	No	Age:
Pulling Self to Stand	Yes	No	Age:	Naming Familiar Objects	Yes	No	Age:
Standing Without Support	Yes	No	Age:	Putting 2 Words Together	Yes	No	Age:
Standing With Support	Yes	No	Age:	Using Short Sentences	Yes	No	Age:

Name of the person completing this form if other than patient**:** ______________________________

Relationship to patient: ______________ Signature: ______________________________